Arizona Health Care Cost Containment System Administration (AHCCCSA)

AHCCCS

2004–2005 External Quality Review Technical Report *for* Acute Care Plans

June 2006

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HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

Introduction

Health Services Advisory Group, Inc. (HSAG) serves as an external quality review organization (EQRO) for the Arizona Health Care Cost Containment System (AHCCCS). This annual technical report complies with 42 Code of Federal Regulations (CFR) 438.364. This report for contract year (CY) 2004-2005 describes how the data from activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed. This report also explains the methodologies used to draw conclusions about the quality and timeliness of and access to care furnished by the following health plans: Arizona Physicians IPA, Care1st Healthplan of Arizona, Health Choice Arizona, Maricopa Health Plan, Mercy Care Plan, Phoenix Health Plan, Pima Health System, University Family Care, and the Arizona Department of Economic Security Comprehensive Medical and Dental Program (DES/CMDP). It includes the following for each activity conducted in accordance with 42 CFR 438.358:

i. Objectives
ii. Technical methods of data collection and analysis
iii. Description of data obtained
iv. Conclusions drawn from the data
v. The extent to which the State provided the necessary information to create this report while safeguarding the identities of patients

Also included in this report is an assessment of each health plan's strengths and opportunities for improvement with respect to the quality and timeliness of and access to health care services furnished to Medicaid members, along with recommendations to improve the quality of health care services each health plan offers. Additionally, each health plan is assessed on the extent to which it has addressed recommendations for quality improvement made the previous year (e.g., performance measures). Furthermore, comparisons across health plans; performance based on quality, timeliness, and access; and performance improvement are highlighted in this report.

The technical methods of data collection and analysis are presented first, including the methods of the EQRO in preparing this report and the methods used by AHCCCS and the health plans as they have been mandated by AHCCCS and which do not differ across health plans. It is important to note that AHCCCS conducted its own data validation from the health plans' performance measure reviews and mandated performance improvement projects (PIPs). The external quality review (EQR) assessment of the data obtained and the conclusions drawn from those data form the basis for the findings presented in each section, both separately for each health plan and comparatively across health plans. In the final section, the report presents the State with recommendations for continued quality improvement in the program beyond the recommendations found in the separate sections.

AHCCCS's Unique Approach

Each state that contracts with health plans must ensure that it has a qualified EQRO perform an annual EQR for each contracting health plan. Each state must also ensure that the EQRO has sufficient information to perform the review. The information for the review must be obtained for the EQR-related activities described in 42 CFR 438.358. In addition, the information provided to the EQRO must be obtained through methods consistent with the protocols established under 42 CFR 438.352. In general, the majority of state Medicaid agencies nationwide competitively bid the mandatory activities required by the federal government in seeking competent EQROs to perform these services. AHCCCS, however, is unique not only as a national model program for managed care, but also for the model it uses for EQR activities. AHCCCS has developed its own expertise and competence to perform many of the mandatory activities, including conducting a review to determine health plan compliance with financial and operational standards, validation of health plan performance measures, and validation of PIPs.

AHCCCS has validated the health plans' performance and reviewed the relevant information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accordance with industry standards for data collection and analysis. To meet the requirement for information that must be produced, AHCCCS contracts with HSAG to provide the External Quality Review Technical Report. HSAG is an EQRO that meets the competence and independence requirements set forth in 42 CFR 438.354.

HSAG Methodology for Data Acquisition and Reporting

On February 1, 2006, AHCCCS and HSAG held initial meetings to discuss the EQR Technical Report contract and mandatory activities. HSAG reviewed materials provided by AHCCCS and developed a compliance with standards summary tool to crosswalk the data provided. Meetings were conducted with AHCCCS both in person and on the telephone to clarify any questions regarding the data received, as needed. A draft report outline was provided to AHCCCS and a first draft of the entire report was provided to AHCCCS for review on April 28, 2006.

Compliance with Standards (Operational and Financial Review)

Objectives for Review of Operational and Financial Review (OFR) Standards

HSAG designed a compliance with standards summary tool to more easily represent the information contained within the nine health plan compliance with standards reports and to facilitate a comparison among health plans. This summary tool focused on the objectives of this analysis, which were to:

1. Determine each health plan's compliance with standards established by the State to comply with the requirements of 42 CFR 438.204(g).
2. Provide data from the review of the compliance with standards that allow conclusions to be drawn as to the quality and timeliness of and access to care furnished by the health plans.
3. Aggregate and assess CAPs to provide an overall evaluation.

AHCCCS Methodology for Review of Operational and Financial Review Standards

The AHCCCS mission is: "Reaching across Arizona to provide comprehensive, quality health care for those in need." In support of that mission, AHCCCS provided health plans with a detailed description of the expectations found in their contracts. AHCCCS also supplied health plans with a list of documents and information that must be available to AHCCCS for review during the OFR.

AHCCCS reviewed the operational and financial performance of health plans throughout the year. The Agency Review Team, which was composed of staff from the Division of Health Care Management, the Office of Legal Assistance, the Division of Business and Finance, and the Office of Program Integrity, performed on-site reviews to interview and observe operations of health plan personnel and to review documentation. The AHCCCS OFR encompassed the following areas:

- General administration
- Delivery system
- Case management
- Grievance system
- Behavioral health
- Utilization management
- Quality management
- Maternal child health
- Financial management
- Reinsurance
- Encounters

Reviews generally require three to five days, depending on the extent of review required and the location of the health plan. The OFRs allowed AHCCCS to:

- Determine the extent to which each health plan met AHCCCS's contractual requirements, AHCCCS policies, and the Arizona Administrative Code.
- Increase its knowledge of each health plan's operational and financial procedures.
- Provide technical assistance and identify areas for improvement and areas of noteworthy performance and accomplishment.
- Review progress in implementing the recommendations made during prior OFRs.
- Determine each health plan's compliance with its own policies and procedures and evaluate their effectiveness.
- Perform health plan oversight as required by the Centers for Medicare & Medicaid Services (CMS) in accordance with the AHCCCS 1115 waiver.

AHCCCS prepared an annual report of review findings and sent it to each health plan. In the report, each standard and substandard was individually listed along with a compliance decision. Full compliance was 90 to 100 percent compliant, substantial compliance was 75 to 89 percent compliant, partial compliance was 50 to 74 percent compliant, and non-compliance was 0 to 49 percent compliant. N/A was not applicable. FIO was for information only.

The report was sent to the health plans with recommendations as follows:

- *The health plan must….* This statement indicates a critical non-compliance area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
- *The health plan should….* This statement indicates a non-compliance area that must be corrected to be in compliance with the AHCCCS contract but is not critical to the everyday operation of the health plan.
- *The health plan should consider….* This statement is a suggestion by the review team to improve the operations of the health plan but is not directly related to contract compliance.

Each health plan submitted a response to each of the first two types of review findings with a proposed CAP. AHCCCS reviewed and approved all CAPs. Health plans have the right to challenge AHCCCS's findings.

Validation of Performance Measures

Objectives for Review of Validation of Performance Measures

In its objectives for the review of validation of performance measures, AHCCCS:

1. Provide each health plan with the necessary information on State-required performance measures.
2. Ensured that each health plan measured and reported to the State its performance on an annual basis using standard measures required by the State.

3. Ensured that validation of health plan performance measures was conducted according to industry standards.

Methodology for Review of Validation of Performance Measures

AHCCCS acquired information to evaluate preventive health care quality through performance measurement data received from each health plan using Health Employer Data and Information Set (HEDIS®) methodology. HEDIS® was developed and is maintained by the National Committee for Quality Assurance (NCQA) and is a widely used and well-accepted set of performance measures for health care providers.

To select the members included in the annual analysis, AHCCCS used HEDIS® criteria (e.g., members must have been continuously enrolled for a specified minimum period of time with the health plan). AHCCCS has also adopted the NCQA's methodology of rotating measurements to produce a more comprehensive annual report of preventive health care services over time without having to collect the entire measure set each year. The approach reduced the administrative burden on the plans without sacrificing substantive oversight. This rotating schedule alternated measures on a biennial basis and made an intervention year possible for quality improvement efforts. It also gave each health plan an opportunity to focus activities on improving specific measures that AHCCCS had identified in its prior annual reports as requiring attention. Nonetheless, children's access to primary care practitioners (PCPs) and adults' access to preventive/ambulatory health services were reported annually.

To acquire data, AHCCCS used its automated managed care data system, the Prepaid Medicaid Management Information System (PMMIS), for all of its managed care plans. Health plan members included in the denominator for each measure were selected from the recipient subsystem of PMMIS. Numerators for each measure represent counts from encounter data, records of medically necessary services, and related claims. AHCCCS also conducted data validation studies to evaluate the completeness, accuracy, and timeliness of encounter data. In CY 2004–2005 (October 1, 2004, through September 30, 2005) for the eight managed care plans and CY 2005 for DES/CMDP, AHCCCS conducted an encounter data validation study on CY 2002 (October 1, 2001, through September 30, 2002) data. AHCCCS estimated the overall accuracy of the plans' encounter data to exceed 95 percent in most cases, with several measures exceeding 98 percent.

Assessment of Performance Improvement Projects (PIPs)

Objectives for Review of PIPs

In its objectives for its assessment of PIPs, AHCCCS:

1. Ensured that each health plan had an ongoing performance improvement program of projects that focused on clinical and non-clinical areas for the services it furnished to its members.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

2. Ensured that each health plan measured performance using objective and quantifiable quality indicators.
3. Ensured that each health plan implemented systemwide interventions to achieve improvement in quality.
4. Evaluated the effectiveness of each health plan's interventions.
5. Ensured that each health plan initiated and planned activities to increase or sustain its improvement.
6. Ensured that each health plan reported the status and results of each project to the State in a reasonable period to allow timely information on the status of PIPs.
7. Annually reviewed the impact and effectiveness of each health plan's performance improvement program.
8. Required that each health plan have an ongoing process to evaluate the impact and effectiveness of its performance improvement program.

Methodology for Review of PIPs

As previously stated for each contract, AHCCCS required that health plans have an ongoing program of PIPs that focused on clinical and nonclinical areas. These projects involved measuring performance by using objective and quantifiable quality indicators, implementing system interventions to achieve performance improvements, evaluating the effectiveness of the interventions, and planning and initiating activities to increase or sustain its improvements.

The PIPs reviewed for this External Quality Review Technical Report were adult management of diabetes (not required of DES/CMDP) and children's oral health. The populations for the two reviewed PIPs were selected according to HEDIS® criteria for their respective projects. Members were excluded if they were tribal members or fee-for-service members not in a health plan due to the inability to accurately collect complete data under those circumstances.

Throughout the process, AHCCCS maintained confidentiality in compliance with Health Insurance Portability and Accountability Act (HIPAA) requirements. The files were maintained on a secure, password-protected computer. Only AHCCCS employees who analyzed the data had access to the database, and all employees were required to sign confidentiality agreements. Furthermore, only the minimum amount of necessary information to complete the project was collected. Upon completion of each study, all information was removed from the AHCCCS computer and placed on a compact disc to be stored in a secured location.

When the data were collected and processed, PIPs were reviewed and assessed by AHCCCS through the use of the criteria found in Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities (Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002). This process involved 10 distinct steps as delineated in the CMS Protocol:

1. Review the selected study topic(s).
2. Review the study question(s).

3. Review selected study indicator(s).
4. Review the identified study population(s).
5. Review sampling methods (if sampling was used).
6. Review the plan's data collection procedures.
7. Assess the plan's improvement strategies.
8. Review the data analysis and the interpretation of the study's results.
9. Assess the likelihood that reported improvement is real improvement.
10. Assess whether the plan has sustained its documented improvement.

The methodology for evaluating each of the 10 steps is covered in detail in the CMS protocol, including acceptable and not acceptable examples of each step. When completed, the PIP assessments were forwarded to each plan. Each plan had the opportunity to comment on the results and actions included in their evaluation from AHCCCS. The overall AHCCCS evaluation reports and plan-specific results were supplied to HSAG by AHCCCS for review and inclusion in this External Quality Review Technical Report.

Overall Findings for All Health Plans

Compliance with Standards (Operational and Financial Review)

Figure 3-1 shows the compliance rates of all health plans with the selected technical standards. The figure shows that 82 percent of the reviewed standards were in full compliance. Almost 90 percent (i.e., 89 percent) were at least in substantial compliance. These results suggest that, overall, the health plans demonstrated competence in the compliance standards.

Figure 3-1—Compliance with Technical Standards *for* All Health Plans

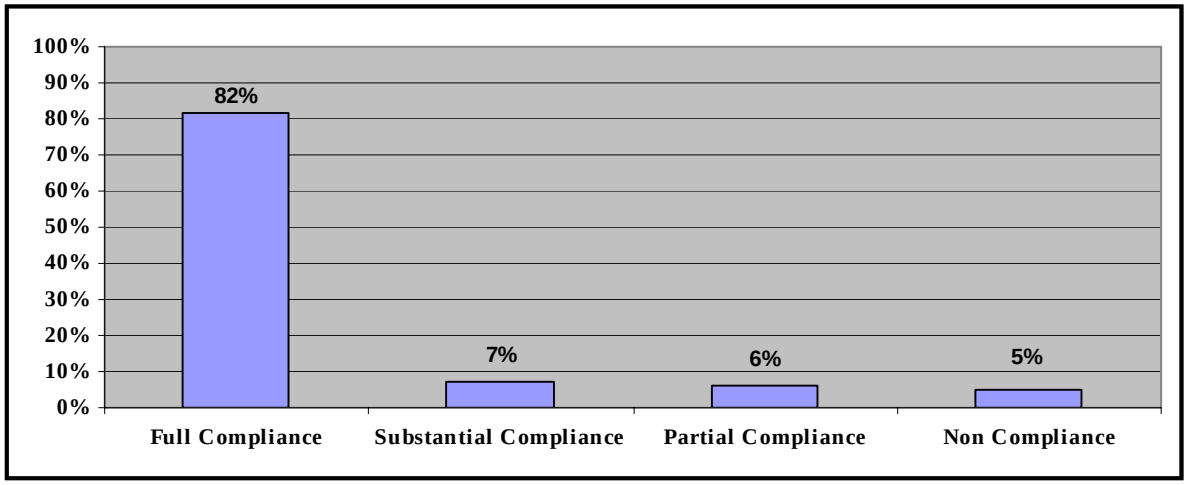


Figure 3-2 shows results for the individual categories of the technical standards, providing the details needed to interpret which areas are in better compliance than others and, conversely, which areas show greater opportunities for improvement.

Figure 3-2—Categorized Levels of Compliance with Technical Standards *for* All Health Plans

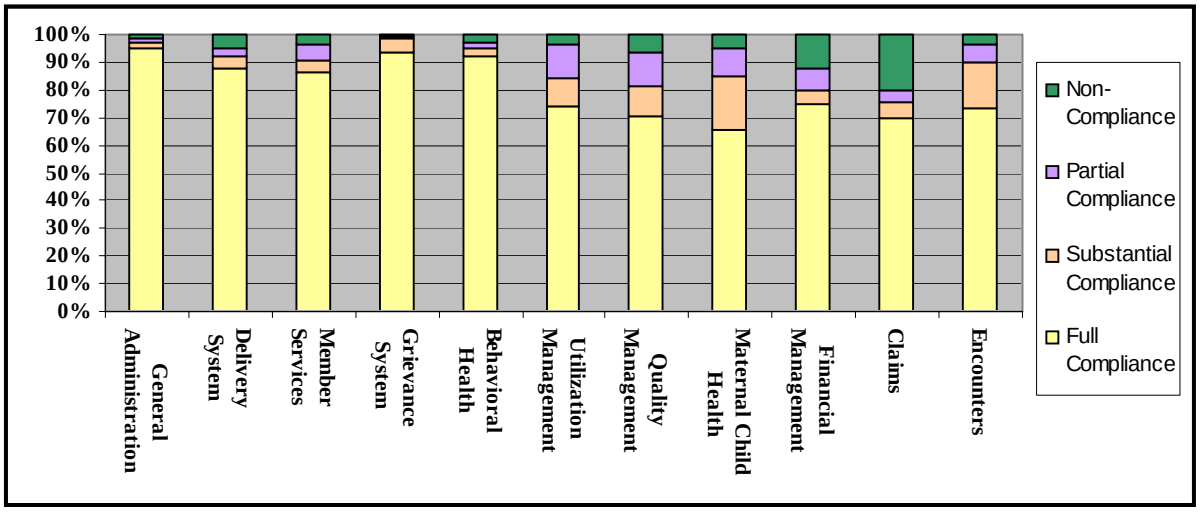


Figure 3-2 shows that the general administration, grievance system, and behavioral health categories all had more than 95 percent of technical standards in at least substantial compliance. Six of the 11 categories were more than 90 percent in substantial compliance. The figure also shows that the claims category had the most opportunity for improvement with 76 percent of standards in at least substantial compliance. AHCCCS also reviewed reinsurance technical standards as part of its review and scored the standards as for information only for all health plans. It should be noted, however, that Medical Management standards were strengthened by AHCCCS, and there was a dramatic increase in the monitoring of this area. AHCCCS rewrote a section of the AHCCCS Medical Policy Manual, increased requirements, and monitored the health plans more rigorously. The health plans still showed improvement over previously monitored results.

Compliance with Standards—Corrective Action Plans (CAPs)

Table 3-1 presents each of the categories of technical standards reviewed, the number of CAPs required, each category's percentage of all CAPs, the number of technical standards in each category, and the percentage of technical standards with a CAP for each category.

The table shows that the behavioral health category had only 1 percent of the CAPs. General administration, behavioral health, and grievance system had a small percentage of standards receiving CAPs. Overall, these categories demonstrated strength across health plans.

In contrast, nearly one in five of CAPs were for the utilization management category, followed by quality management and delivery system. Claims, quality management, and maternal child health had at least 30 percent of their standards requiring a CAP. These three categories had the greatest opportunity for improvement. Overall, 18 percent of technical standards required a CAP.

Table 3-1—CAP Overview *for* All Plans

Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards Across Plans	CAPs as Percent of Standards
General Administration	18	5%	335	5%
Delivery System	50	13%	295	17%
Member Services	23	6%	179	13%
Grievance System	13	4%	175	7%
Behavioral Health	4	1%	62	6%
Utilization Management	70	19%	288	24%
Quality Management	56	15%	185	30%
Maternal Child Health	35	9%	117	30%
Financial Management	36	10%	143	25%
Claims	30	8%	95	32%
Encounters	36	10%	133	27%
Total	**371**	**100%**	**2,007**	**18%**

Performance Measure Review

Table 3-2 presents the mean rates across the nine health plans during the two most recent measurement periods for each of the performance measures. All available information was used. Where there were no data for some of the measures, the mean was calculated from the available data.

The table shows that of the 26 rates collected this reporting cycle, there was marginal improvement across acute health care plans statewide with 19 of the 22 comparable performance measure rates improved. Nonetheless, the actual rates suggested that, on average, documentation of services was absent for approximately one quarter to two-thirds of the performance measures. Medicaid adolescent well-care visits had the lowest rate for actual performance while child immunization – 1 MMR – KidsCare showed the highest rate at 96.7 percent for the current measurement period.

Table 3-2—Performance Measurement Programs Overall

Performance Measure	Previous Measurement Period	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Minimum AHCCCS Performance Standard
Children's Access to PCPs – Medicaid	74.9%	77.3%	79%
Children's Access to PCPs – KidsCare	76.1%	77.9%	79%
Adults Preventive/Ambulatory Care	74.6%	76.1%	80%
Well-Child Visits – First 15 Months – Medicaid	68.8%	64.8%	70%
Well-Child Visits – 3 to 6 Yrs – Medicaid	53.0%	56.9%	55%
Well-Child Visits – 3 to 6 Yrs – KidsCare	59.8%	60.9%	55%
Adolescent Well-Care Visits – Medicaid	34.1%	35.2%	32%
Adolescent Well-Care Visits – KidsCare	37.8%	37.1%	32%
Annual Dental Visits – Medicaid	49.9%	54.1%	49%
Annual Dental Visits – KidsCare	59.1%	61.9%	49%
Child Immunization – 4 DTP – Medicaid	78.3%	82.8%	83%
Child Immunization – 4 DTP – KidsCare	83.9%	89.6%	83%
Child Immunization – 3 IPV – Medicaid	90.8%	91.7%	89%
Child Immunization – 3 IPV – KidsCare	95.0%	94.0%	89%
Child Immunization – 1 MMR – Medicaid	93.2%	93.8%	90%
Child Immunization – 1 MMR – KidsCare	94.5%	96.7%	90%
Child Immunization – 3 HiB – Medicaid	N/A[1]	87.2%	76%
Child Immunization – 3 HiB – KidsCare	N/A[1]	90.8%	76%
Child Immunization – 3 HBV – Medicaid	83.9%	86.5%	82%
Child Immunization – 3 HBV – KidsCare	88.7%	89.2%	82%
Child Immunization – 1 VZV – Medicaid	79.5%	86.5%	77%
Child Immunization – 1 VZV – KidsCare	84.6%	90.6%	77%

Table 3-2—Performance Measurement Programs Overall			
Performance Measure	Previous Measurement Period	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Minimum AHCCCS Performance Standard
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – Medicaid	75.3%	80.2%	80%
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare	81.2%	87.8%	80%
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – Medicaid	N/A[1]	70.0%	70%
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – KidsCare	N/A[1]	78.2%	70%
[1] Current and previous rates are not comparable due to a change in methodology. In the previous measurement, rates for two doses of Hib were reported.			

Performance Measures—CAPs

Table 3-3 presents the percentages of acute health care plans with CAPs for each of the 26 current performance measures. The table shows that the percentages range from a low of zero percent of plans with a CAP for several of the performance measures to 100 percent of plans that are required to develop and institute a CAP for adults preventive/ambulatory care. At least half of health care plans required a CAP for 7 of the 26 performance measures (27 percent). On average, each health plan required six CAPs for the performance measures, as shown at the bottom of the table.

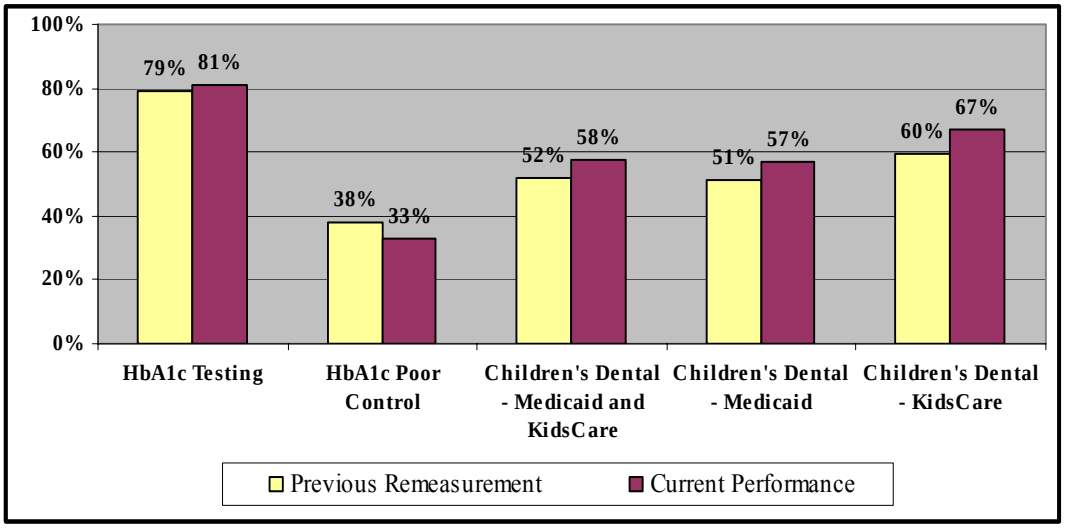
Table 3-3—Performance Measures – Percent of Plans with a CAP	
Performance Measure	Percent
Children's Access to PCPs – Medicaid	56%
Children's Access to PCPs – KidsCare	50%
Adults Preventive/Ambulatory Care	100%
Well-Child Visits – First 15 Months – Medicaid	75%
Well-Child Visits – 3 to 6 Yrs – Medicaid	33%
Well-Child Visits – 3 to 6 Yrs – KidsCare	13%
Adolescent Well-Care Visits – Medicaid	33%
Adolescent Well-Care Visits – KidsCare	13%
Annual Dental Visits – Medicaid	11%
Annual Dental Visits – KidsCare	0%
Child Immunization – 4 DTP – Medicaid	50%
Child Immunization – 4 DTP – KidsCare	13%
Child Immunization – 3 IPV – Medicaid	13%
Child Immunization – 3 IPV – KidsCare	13%
Child Immunization – 1 MMR – Medicaid	0%

Table 3-3—Performance Measures – Percent of Plans with a CAP	
Performance Measure	**Percent**
Child Immunization – 1 MMR – KidsCare	0%
Child Immunization – 3 HiB – Medicaid	0%
Child Immunization – 3 HiB – KidsCare	0%
Child Immunization – 3 HBV – Medicaid	13%
Child Immunization – 3 HBV – KidsCare	13%
Child Immunization – 1 VZV – Medicaid	0%
Child Immunization – 1 VZV – KidsCare	0%
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – Medicaid	50%
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare	14%
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – Medicaid	50%
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – KidsCare	14%
Average Number of CAPs per Plan	**6**

Review of Performance Improvement Projects (PIPs)

Figure 3-3 presents the change in PIP performance for the two most recent measurement periods, averaged across the health plans. The figure shows improved performance for every measure. The HbA1c poor control measure is a reverse measure for which lower values are better than higher rates; therefore, the lower rate shown for the current measurement period represents improvement in the measure's rate. The health plans also improved their adult diabetes management rates between baseline and the first remeasurement cycle. Both measures of children's dental care met or exceeded the AHCCCS benchmark rate.

Figure 3-3—Average PIP Performance Across the Two Most Recent Measurement Periods



Strengths, Opportunities for Improvement, and Recommendations for Arizona Plans

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

When jointly considered, Figure 3-2 and Table 3-1 suggest that three categories stand out as demonstrated strengths across the health plans covered in this technical report. General administration, behavioral health, and grievance system were the only categories for the compliance with standards review that showed the percentage of CAPs to be below 10 percent for both methods of analysis: (1) the category's percentage of all CAPs and (2) CAPs as a percentage of the standards within each category. Additionally, the three categories had rates of full compliance that were relatively high and rates of non-compliance that were relatively low.

Opportunities for Improvement and Recommendations

Figure 3-2 shows that the areas of claims and financial management were relatively high for non-compliance ratings. Furthermore, these two areas, as well as utilization management, quality management, maternal child health, and encounters had high percentages of CAPs, as seen in Table 3-1. Taken together, the results suggest that these five areas could be opportunities for improvement for the compliance with standards review.

Due to less-than-substantial compliance at the individual technical standard level, HSAG recommends that all acute health care plans promote initiatives to:

- Ensure timely notification of AHCCCS regarding third party liability cases.
- Ensure the provision of Notice of Intended Action forms to members.
- Ensure that processes are in place to improve performance measure results.
- Ensure monitoring of member compliance with EPSDT services and the provision of prenatal care.

Performance Measure Review

Strengths

Overall, Table 3-2 and Table 3-3 show the performance measures to be a strength for the health plans. Table 3-2 shows that, on average, 21 of 26 measures met or exceeded the minimum AHCCCS performance standards. Annual dental visits – KidsCare, child immunization – 3 HiB – Medicaid, child immunization – 3 HiB – KidsCare, and child immunization – 1 VZV – KidsCare each exceeded the minimum AHCCCS performance standards by more than 10 percentage points.

Also in Table 3-2, children's access to PCPs – Medicaid, children's access to PCPs – KidsCare, adults' preventive/ambulatory care, well-child visits – first 15 months – Medicaid, and child

immunization – 4 DTP – Medicaid showed opportunities for improvement. Each of these measures failed to meet the minimum AHCCCS performance standards when averaged across all reviewed health plans. Child immunization – 4 DTP – Medicaid, however, failed to average the minimum standard by only 0.2 percentage points.

Table 3-3 adds more information about strengths from the performance measure review because the number of CAPs, or lack thereof, for each performance measure is an additional metric of importance. Using this metric, the table shows that no single health plan had a CAP for the current period under review for the following performance measures: annual dental visits – KidsCare, child immunization – 1 MMR – Medicaid, child immunization – 1 MMR – KidsCare, child immunization – 3 HiB – Medicaid, child immunization – 3 HiB – KidsCare, child immunization – 1 VZV – Medicaid, and child immunization – 1 VZV – KidsCare. Therefore, these seven performance measures were strengths across each of the health plans.

Opportunities for Improvement and Recommendations

Every health plan required CAP for adults preventive/ambulatory care. A CAP was also required for 75 percent of the plans for well-child visits – first 15 months – Medicaid. Additionally, about 50 percent of the plans were required to implement a CAP for children's access to PCPs – Medicaid; children's access to PCPs – KidsCare; child immunization – 4 DTP – Medicaid, child immunization – DTP, IPV, & MMR (4:3:1 series) – Medicaid; and Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 series) – Medicaid. Overall, the rates for the KidsCare measures required fewer health plans to conduct a CAP than did the rates for the Medicaid measures. HSAG recommends that plans implement processes to improve their performance on adults' preventive/ambulatory care and well-child visits – first 15 months – Medicaid because these areas showed the most uniform opportunity for improvement statewide.

Review of PIPs

Strengths

Figure 3-3 shows that all measures used in the PIPs improved between measurement cycles, overall. Although HbA1c poor control had a lower rate in the most recent measurement cycle, the measure is reversed, meaning that lower rates are indicative of better performance. HbA1c poor control was a strength because the measure's rate declined for only one of the seven health plans reporting the measure. Nonetheless, health plans demonstrated improvement from the baseline measurement to the first remeasurement for diabetes management, and sustained that performance through the second remeasurement cycle. Children's annual dental visits for Medicaid, however, had more opportunities for improvement statewide because rates decreased in two of eight plans reporting the measure.

Opportunities for Improvement and Recommendations

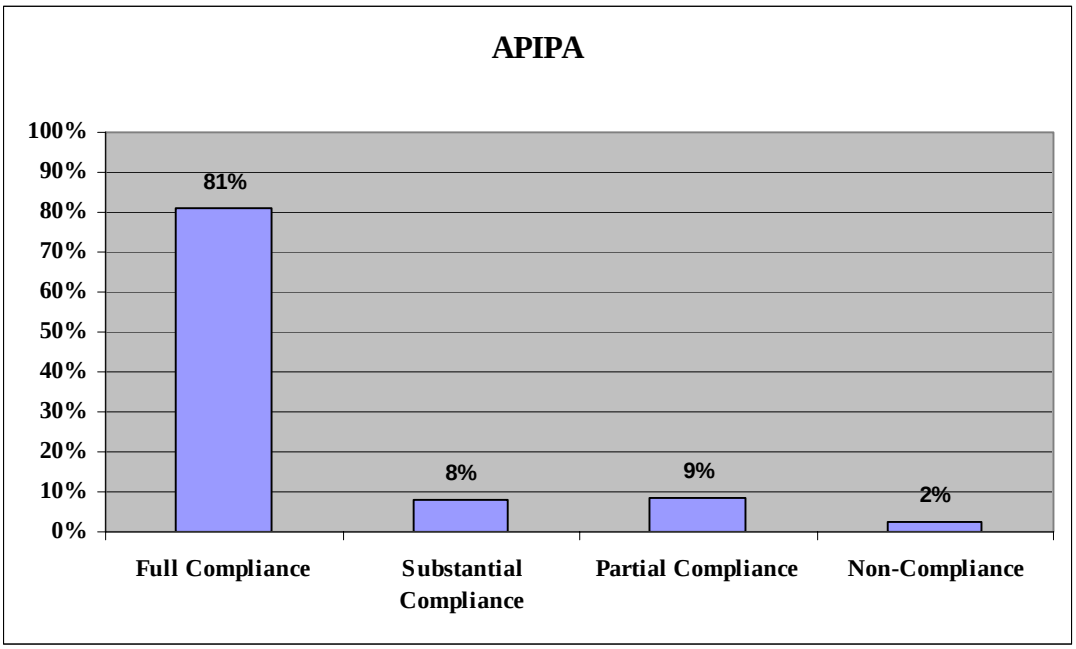
With continuation of the children's oral health PIP, the health plans will have additional time to improve their rates. Three of eight health plans had not yet reached the AHCCCS benchmark for their Medicaid members. For KidsCare, only one of seven health plans failed to meet the AHCCCS benchmark. This finding bolsters the recommendation that the state's health plans focus improvement efforts more toward Medicaid members than toward KidsCare members, although KidsCare members should have their rates monitored to ensure that rates remain relatively high.

Arizona Physicians IPA (APIPA)

Compliance with Standards (Operational and Financial Review)

Figure 3-4 shows the APIPA percentage of compliance with the technical standards selected for review in CY 2004-2005. The percentages of the standards in full compliance, substantial compliance, partial compliance, and non-Compliance are separately shown.

Figure 3-4—Compliance with Technical Standards *for* APIPA



The difference between at least partial compliance (the sum of full, substantial, and partial compliance) and full compliance (which can be represented as 98 percent – 81 percent = 17 percent) reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving it. This scenario contrasts with non-compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving the technical standards), the health plan might make large strides in attaining full compliance with relatively little effort. Moving a technical standard from non-compliance to full compliance, however, might require additional educational and other activities, although there were few technical standards in non-compliance (2 percent) for APIPA.

Figure 3-5 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights both areas of strength and opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on full compliance, substantial compliance, partial compliance, and non-compliance.

Figure 3-5—Categorized Levels of Compliance with Technical Standards *for* APIPA

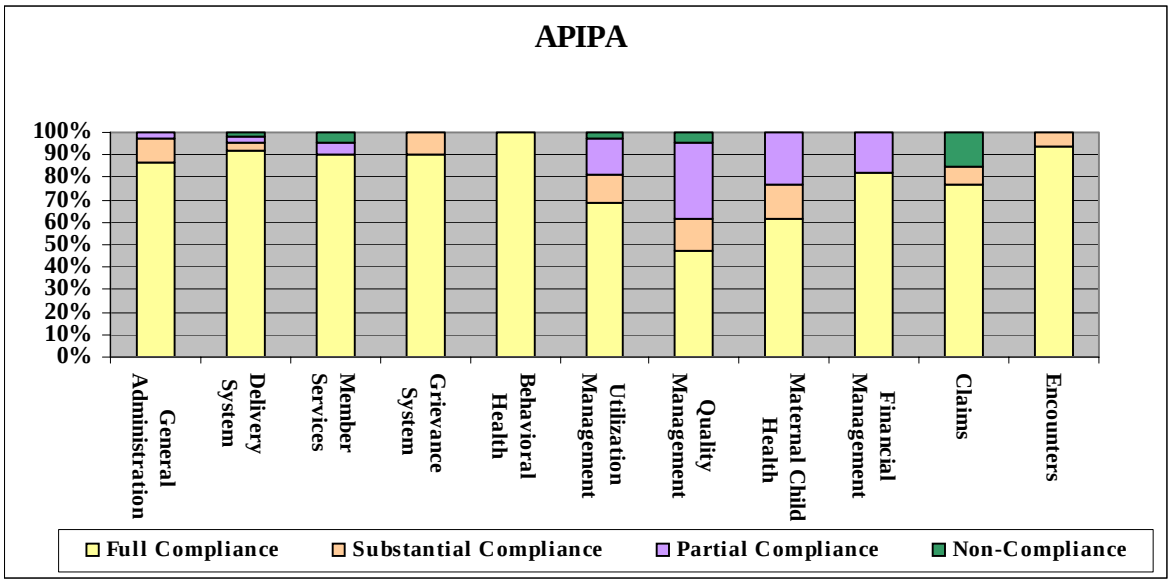


Figure 3-5 shows that behavioral health is the only category in full compliance with all of the individual technical standards. Quality management is the area with the greatest opportunity for improvement. All of the technical standards reviewed for grievance system and encounters were in either full or substantial compliance. Non-compliance was greatest for technical standards in the claims category.

Next year, APIPA should eliminate the non-compliance findings, move the partial compliance findings to at least substantial compliance, and move the substantial compliance findings to full compliance. Moving technical standards that are not fully compliant in the direction of full compliance could be achieved. Special attention should be given to quality management, which had less than half of its technical standards in full compliance. Overall, 199 technical standards were in full compliance, 19 in substantial compliance, 21 in partial compliance, and 6 in non-compliance.

CAPs for Compliance with Standards

Table 3-4 presents each of the categories of technical standards reviewed, the number of CAPs required, each category's percentage of all CAPs, the number of technical standards in each category, and the percentage of the technical standards with a CAP for each category.

The table shows that, based on the number of CAPs required, quality management and utilization management had the greatest opportunities for improvement. There was also opportunity for improvement in maternal child health based on the category's percentage of standards with a CAP.

APIPA did not receive a single CAP for behavioral health, making that category a recognized strength. Additionally, encounters only received one CAP, accounting for 2 percent of all of the CAPs and representing only 7 percent of the number of technical standards in its category. Overall, 20 percent of the technical standards required a CAP.

Table 3-4—CAP Overview *for* APIPA				
Categories of Technical Standards	**Number of CAPs**	**Percent of Total CAPs**	**Total Number of Standards**	**CAPs as a Percent of Standards**
General Administration	4	8%	38	11%
Delivery System	6	12%	48	13%
Member Services	2	4%	21	10%
Grievance System	2	4%	20	10%
Behavioral Health	0	0%	7	0%
Utilization Management	9	18%	32	28%
Quality Management	12	24%	21	57%
Maternal Child Health	6	12%	13	46%
Financial Management	4	8%	17	24%
Claims	3	6%	13	23%
Encounters	1	2%	15	7%
Total	**49**	**100%**	**245**	**20%**

Performance Measure Review

Table 3-5 shows the separate performance measures for the two most recent time periods, along with the statistical significance level for each of the changes in rates over time. Additionally, the table presents the CY 2004 minimum AHCCCS performance standards and whether a CAP was required.

Table 3-5 shows that for 19 of the 22 comparable measures, performance improved between the current and previous measurement periods. Two of the measures were unchanged (i.e., children's access to PCPs – KidsCare and child immunization – 3 IPV – KidsCare) while only well-child visits – first 15 months – Medicaid showed a decrease. Some of the measures, including child immunization – 3 HBV – Medicaid, increased substantially.

The table shows that 16 of the 19 increases in rates were sufficiently large to be statistically significant. This finding suggests that the 16 changes in rates between the two most recent measurement periods were genuine increases. This number of statistically significant increases in performance measure rates represents 72 percent of the comparable rates across the two most recent measurement cycles. The improvement of the performance measures is evidence of a functioning quality improvement program at APIPA.

Table 3-5—Performance Measurement Programs *for* APIPA					
Performance Measure	Previous Measurement Period**	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Significance Level***	CY 2004 Minimum AHCCCS Performance Standard	CAP Required
Children's Access to PCPs – Medicaid	76.3%	77.1%	p<.001	79%	Yes
Children's Access to PCPs – KidsCare	77.5%	77.5%	p=.918	79%	Yes
Adults' Preventive/Ambulatory Care	76.3%	77.8%	p<.001	80%	Yes
Well-Child Visits – First 15 Months – Medicaid*	69.4%	66.0%	p<.001	70%	Yes
Well-Child Visits – 3 to 6 Yrs – Medicaid	52.2%	56.6%	p<.001	55%	No
Well-Child Visits – 3 to 6 Yrs – KidsCare	53.2%	57.1%	p=.041	55%	No
Adolescent Well-Care Visits – Medicaid	30.7%	32.9%	p<.001	32%	No
Adolescent Well-Care Visits – KidsCare	32.3%	36.6%	p<.001	32%	No
Annual Dental Visits – Medicaid	47.0%	52.1%	p<.001	49%	No
Annual Dental Visits – KidsCare	52.8%	58.7%	p<.001	49%	No
Child Immunization – 4 DTP – Medicaid	71.7%	80.7%	p<.001	83%	Yes
Child Immunization – 4 DTP – KidsCare	80.1%	87.4%	p=.023	83%	No
Child Immunization – 3 IPV – Medicaid	85.9%	89.9%	p<.001	89%	No
Child Immunization – 3 IPV – KidsCare	91.3%	91.3%	p=.984	89%	No
Child Immunization – 1 MMR – Medicaid	89.0%	90.7%	p=.091	90%	No
Child Immunization – 1 MMR – KidsCare	91.3%	95.3%	p=.067	90%	No
Child Immunization – 3 HiB – Medicaid	N/A[1]	82.8%	N/A[1]	76%	No
Child Immunization – 3 HiB – KidsCare	N/A[1]	83.5%	N/A[1]	76%	No
Child Immunization – 3 HBV – Medicaid	76.4%	87.8%	p<.001	82%	No
Child Immunization – 3 HBV – KidsCare	85.7%	89.8%	p=.154	82%	No
Child Immunization – 1 VZV – Medicaid	71.8%	80.7%	p<.001	77%	No
Child Immunization – 1 VZV – KidsCare	79.1%	87.8%	p=.007	77%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – Medicaid	68.4%	77.5%	p<.001	80%	Yes
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare	76.0%	85.8%	p=.004	80%	No
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – Medicaid	N/A[1]	69.3%	N/A[1]	70%	Yes
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – KidsCare	N/A[1]	76.0%	N/A[1]	70%	No

* There were not enough KidsCare members who met the enrollment criteria to measure a rate for this group.

[1] Current and previous rates are not comparable due to a change in methodology. In the previous measurement, rates for two doses of Hib were reported.

** Children's access to PCPs, adults' preventive/ambulatory care, and child immunizations are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

*** Significance levels ($p \leq .05$) noted in the table demonstrate the statistical significance between performance for the previous measurement period and performance for the current measurement period.

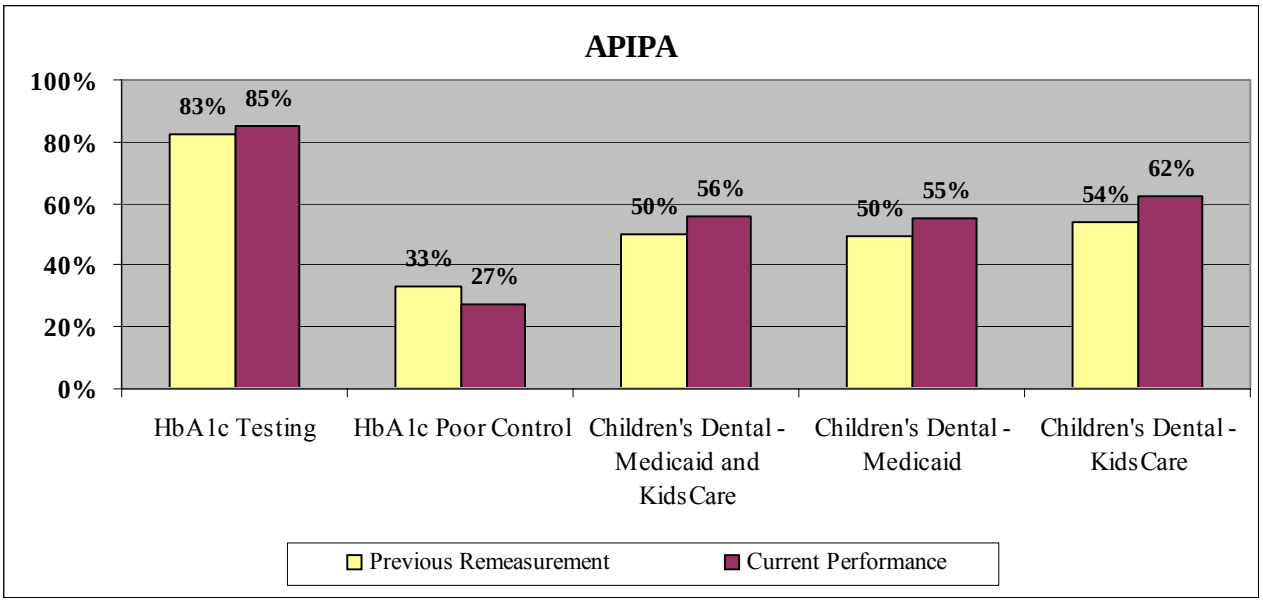
Performance Measures—CAPs

Table 3-5 also shows which performance measures required CAPs. Seven of the 26 measures for APIPA required a CAP for the current review period. Importantly, 10 of the measures not requiring a CAP this year would have required one under the same minimum AHCCCS performance standard in the previous measurement cycle. This finding suggests that passing all of the current measures during the next measurement cycle could be an obtainable goal for APIPA.

Review of PIPs

Figure 3-6 presents the results of APIPA's two PIPs, adult diabetes management and children's oral health. The figure shows improvement in each of the measures used to assess these PIPs. Furthermore, the rates for the diabetes indicators are strong from a national perspective. The HbA1c measure was above the national 75th percentile HEDIS® Medicaid benchmark. The HbA1c poor control measure, for which a decrease (as shown in the figure) indicates improvement, was lower than the HEDIS® 10th percentile benchmark (i.e., the equivalent of exceeding the 90th percentile benchmark for a more traditional measure in which higher rates are indicative of better performance). The children's oral health measures did not reach the AHCCCS benchmark of 57 percent for Medicaid members, but the measures did reach the benchmark for KidsCare members.

Figure 3-6—PIP Results *for* APIPA



Strengths, Opportunities for Improvement, and Recommendations for APIPA

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

In Figure 3-5 and Table 3-4, three categories stand out as demonstrated strengths: grievance system, behavioral health, and encounters. These three categories were at least 90 percent in full compliance, had no technical standards that received less than substantial compliance, and had no more than two CAPs.

Opportunities for Improvement and Recommendations

Figure 3-5 shows that quality management and maternal child health have opportunities for improvement. Table 3-4 shows that approximately half of the technical standards in each of the two categories were required to institute a CAP. Furthermore, the claims category showed the greatest number of technical standards in non-compliance, suggesting that claims could be targeted for improvement activities.

Specifically, recommendations to improve APIPA performance include the following:

- APIPA policies, procedures, and processes need to be enhanced to include specific AHCCCS requirements related to:
  - Concurrent review for inpatient stays.
  - Quality-of-care issues raised by members.
  - Improving performance measure results.
  - Credentialing.
  - Primary care physician assignment to new members within specified time frames.
  - Prior authorization and adaptation of an interrater reliability plan.
- For the significant number of standards related to provider network monitoring that were out of compliance, areas recommended for improvement include:
  - Ensuring providers maintain comprehensive medical records and include required information.
  - Ensuring there is appropriate supervision of care by licensed professionals.
  - Ensuring that member materials and notices have been provided to members.
- Specific areas of medical management that require improvement include monitoring member compliance with EPSDT services and ensuring provision of prenatal care.
- Other areas of focus for APIPA are concentrated in management of the plan. These focus areas include:
  - Ensuring Notice of Intended Action forms are presented to members.
  - Ensuring that APIPA maintains a cultural competency training program for its employees.
  - Ensuring that monthly, quarterly, and annual financial reports are complete.
  - Ensuring that claims are paid and reports are accurate and within the specified time frames.
  - Ensuring proper notification is made for third party liability cases.

Performance Measure Review

Strengths

Improvement in 19 of the 22 comparable rates was a strength for APIPA. Furthermore, 16 of these 19 improvements were statistically significant. This finding suggests that a well-functioning quality improvement program was in place for APIPA.

Opportunities for Improvement and Recommendations

The health plan required seven CAPs for the performance measures. Although there was improvement, the outcome of the improvement methodologies, as measured by the actual performance rates, was still a weakness for APIPA. If the health plan can maintain its current improvement profile for a couple more years, the number of CAPs might substantially decrease. Further, it is recommended that APIPA focus on methods to improve children's access to PCPs, adults' preventive/ambulatory care, and comprehensive childhood immunizations. Improving these three areas will help APIPA meet the state's minimum performance requirements.

Review of PIPs

Strengths

The adult diabetes management PIP did well when assessed against both local and national frames of reference and is a demonstrated strength for APIPA. The children's oral health PIP showed improvement between the two most recent measurement cycles.

Opportunities for Improvement and Recommendations

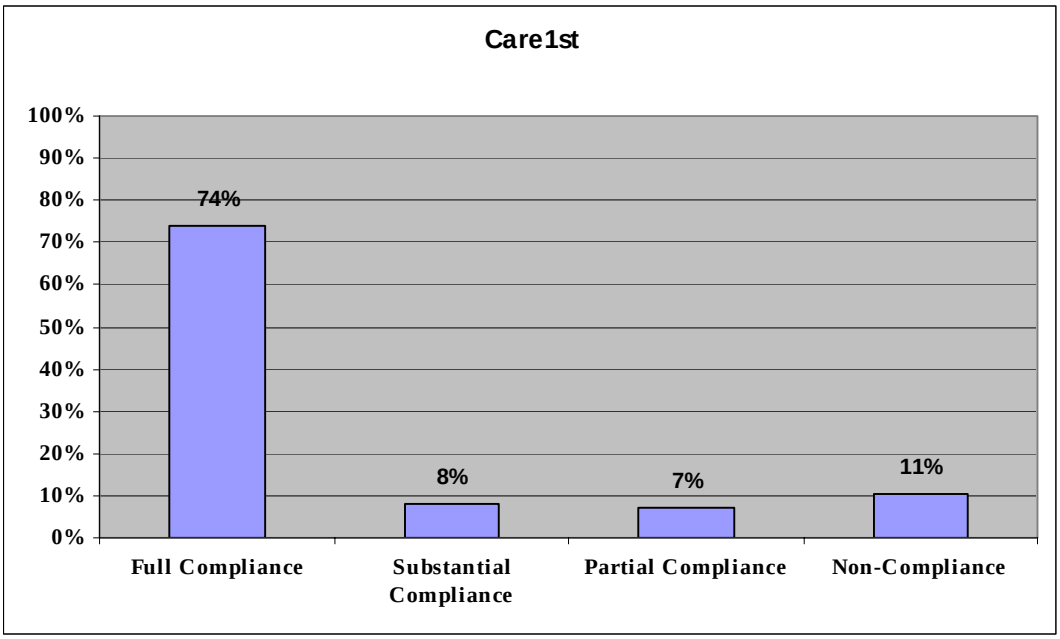
Given the higher performance by the KidsCare population and the lack of achieving the AHCCCS benchmark by the Medicaid population for children's oral health, it is recommended that the health plan strive to improve the rate of children's dental visits by a few more percentage points for Medicaid members.

Care1st Healthplan of Arizona (Care1st)

Compliance with Standards (Operational and Financial Review)

Figure 3-7 shows the percentage of compliance with the technical standards selected for review in CY 2004-2005 for Care1st. The percentages of standards in full compliance, substantial compliance, partial compliance, and non-compliance are shown separately.

Figure 3-7—Compliance with Technical Standards *for* Care1st



The difference between at least partial compliance (the sum of full, substantial and partial compliance) and full compliance (which can be represented by 89 percent – 74 percent = 15 percent) reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving it. This scenario contrasts with the 11 percent non-compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving the technical standards), the health plan might make large strides to attain full compliance with relatively little effort. Moving a technical standard from non-compliance to full compliance, however, might require additional educational and other activities.

Figure 3-8 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights both areas of strength and opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on full compliance, substantial compliance, partial compliance, and non-compliance. The figure shows some large compliance differences across the various compliance categories.

Figure 3-8—Categorized Levels of Compliance with Technical Standards *for* Care1st

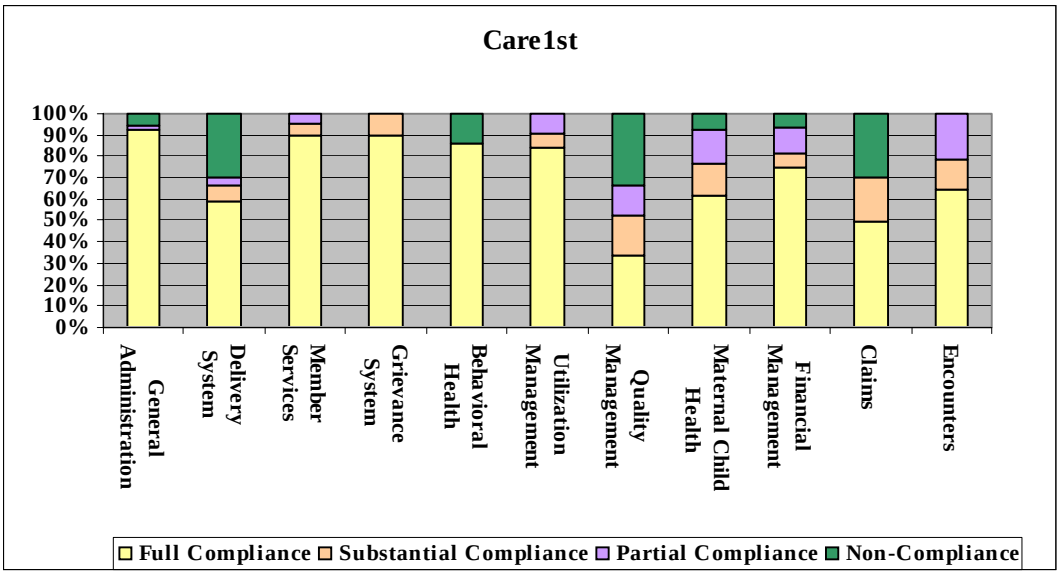


Figure 3-8 shows that all of the technical standards in the grievance system category are in either full compliance (90 percent) or substantial compliance (10 percent). In contrast, quality management shows only one-third of the technical standards in full compliance and another one-third in non-compliance. Care1st's performance across the categories of compliance standards varies considerably. Three of the 11 categories show at least 30 percent of the standards in non-compliance while another three categories are at least 90 percent in full compliance with the standards. Overall, 161 technical standards were in full compliance, 18 in substantial compliance, 16 in partial compliance, and 23 in non-compliance.

CAPs for Compliance with Standards

Table 3-6 presents each of the categories of technical standards reviewed, the number of CAPs required, each category's percentage of all CAPs, the number of technical standards in each category, and the percentage of technical standards with a CAP for each category.

The table shows that delivery system and quality management had the greatest opportunities for improvement. Together, these two categories account for almost half of all of the CAPs required for compliance with standards.

Conversely, behavioral health had only one CAP, which was the lowest count for any of the 11 categories in the compliance with standards review. Member services and grievance system each had two CAPs, while general administration and maternal child health each had three CAPs.

Overall, 25 percent of the technical standards required a CAP in the current review cycle. This finding suggests that Care1st needs to put more resources into their systems and procedures associated with the compliance with standards review.

Table 3-6—CAP Overview *for* Care1st				
Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
General Administration	3	5%	38	8%
Delivery System	11	20%	27	41%
Member Services	2	4%	20	10%
Grievance System	2	4%	20	10%
Behavioral Health	1	2%	7	14%
Utilization Management	5	9%	32	16%
Quality Management	15	27%	21	71%
Maternal Child Health	3	5%	13	23%
Financial Management	4	7%	16	25%
Claims	4	7%	10	40%
Encounters	5	9%	14	36%
Total	**55**	**100%**	**218**	**25%**

Performance Measure Review

Table 3-7 shows the separate performance measures for the two most recent time periods, along with the statistical significance level for each of the changes in rates over time. Additionally, the table presents the CY 2004 minimum AHCCCS performance standards and whether a CAP was required.

Care1st only became eligible for the performance measure review this year; therefore, there were no previous data. The assessment of performance was, therefore, only against the minimum AHCCCS performance standards. Care1st was only required to present data on the measures shown in the table.

Table 3-7—Performance Measurement Programs *for* Care1st					
Performance Measure	Previous Measurement Period*	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Significance Level**	CY 2004 Minimum AHCCCS Performance Standard	CAP Required
Children's Access to PCPs – Medicaid	N/A	69.7%	N/A	79%	Yes
Children's Access to PCPs – KidsCare	N/A	71.6%	N/A	79%	Yes
Adults Preventive/Ambulatory Care	N/A	70.6%	N/A	80%	Yes
Well-Child Visits – 3 to 6 Yrs – Medicaid	N/A	54.6%	N/A	55%	Yes
Well-Child Visits – 3 to 6 Yrs – KidsCare	N/A	54.5%	N/A	55%	Yes
Adolescent Well-Care Visits – Medicaid	N/A	30.8%	N/A	32%	Yes
Adolescent Well-Care Visits – KidsCare	N/A	34.4%	N/A	32%	No
Annual Dental Visits – Medicaid	N/A	50.5%	N/A	49%	No
Annual Dental Visits – KidsCare	N/A	59.5%	N/A	49%	No
* Care1st was not included in this Performance Measure. ** Significance Levels (p-value) could not be calculated for any of the Care1st measures.					

Performance Measures—CAPs

Table 3-7 shows that the six of nine measures that failed to reach the CY 2004 minimum AHCCCS performance standard were each assigned a CAP. Some of the measures showed rates at about ten percentage points below the minimum standard (e.g., children's access to PCPs – Medicaid and adults preventive/ambulatory care). Considerable room for improvement currently exists for these relatively low rates. These measures in particular should be viewed as prime opportunities for improvement.

Review of PIPs

Although Care1st has not been a contractor long enough to participate with other health plans in the AHCCCS PIPs focusing on diabetes management and children's oral health performance, Care1st conducted its own PIP for diabetes management. Care1st reported that 87 percent of members with diabetes received at least two HbA1c tests during the measurement period, October 1, 2003, through September 30, 2004. In addition, Care1st reported that 85 percent of members had a fasting lipid profile for the measurement period October 1, 2003, through September 30, 2004.

Strengths, Opportunities for Improvement, and Recommendations for Care1st

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation, opportunities for improvement and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

Figure 3-8 and Table 3-6 show that member services, grievance system, and utilization management were strengths for Care1st. The scores in the three categories were 90 percent or higher for full compliance and substantial compliance combined.

Opportunities for Improvement and Recommendations

Delivery system, quality management, claims, and encounters represent substantial opportunities for improvement. Quality management represented 27 percent of all the CAPs for compliance with standards and required a CAP for 71 percent of the technical standards in that category.

Recommendations to improve performance by Care1st can be summarized by the following:

- Care1st policies, procedures, and processes need to be enhanced to include specific AHCCCS requirements related to:
  - Utilization management.
  - Peer review.
  - Member transitions, including participation in and discharge from Children's Rehabilitative Services (CRS).

- There were a significant number of standards related to provider network monitoring that were out of compliance. Specific areas requiring improvement include:
  - Monitoring delegated/subcontracted activities.
  - Monitoring provider compliance with AHCCCS appointment standards and member waiting times.
  - Ensuring providers maintain comprehensive medical records and include required information.
  - Verifying and maintaining credentialing and recredentialing information for providers.
  - Ensuring that provider subcontracts contain contractually required information.
  - Monitoring provider compliance with national practice guidelines.
- Specific areas of medical management that require improvement include monitoring member compliance with prenatal care within the prescribed time frames.
- Other areas of focus for Care1st were concentrated in management of the plan. These focus areas include:
  - Ensuring Notice of Intended Action forms are presented to members and members are aware of their basic rights.
  - Coordinating care with other related agencies and programs for service.
  - Ensuring that encounter ratios are within AHCCCS standards for performance.
  - Ensuring that monthly, quarterly, and annual financial reports are complete.
  - Ensuring that member services staff appropriately identifies and documents all member grievances.
  - Ensuring that claims are paid and reports are accurate and within the specified time frames.
  - Ensuring proper notification is made for third party liability cases.

Performance Measure Review

Strengths

The rates for annual dental visits, KidsCare and Medicaid, and adolescent well-care for KidsCare were above the minimum AHCCCS standards and were, therefore, seen as strengths to the health plan's program.

Opportunities for Improvement and Recommendations

With six of nine performance measures failing to meet the minimum AHCCCS performance standards and without a previous record from which to assess improvement, the performance measure review stands as an opportunity for improvement, overall. Further, it is recommended that Care1st focus on methods to improve children's access to PCPs and adults' preventive/ambulatory care. These two areas show the most room for improvement in meeting the state's minimum requirements.

Review of PIPs

Strengths

Care1st has not been a contracted health care provider long enough to have an adult diabetes management or a children's oral health PIP required for review at this time. Nonetheless, the reported rates for adult diabetes management compare quite favorably with national benchmarks for the selected measures.

Opportunities for Improvement and Recommendations

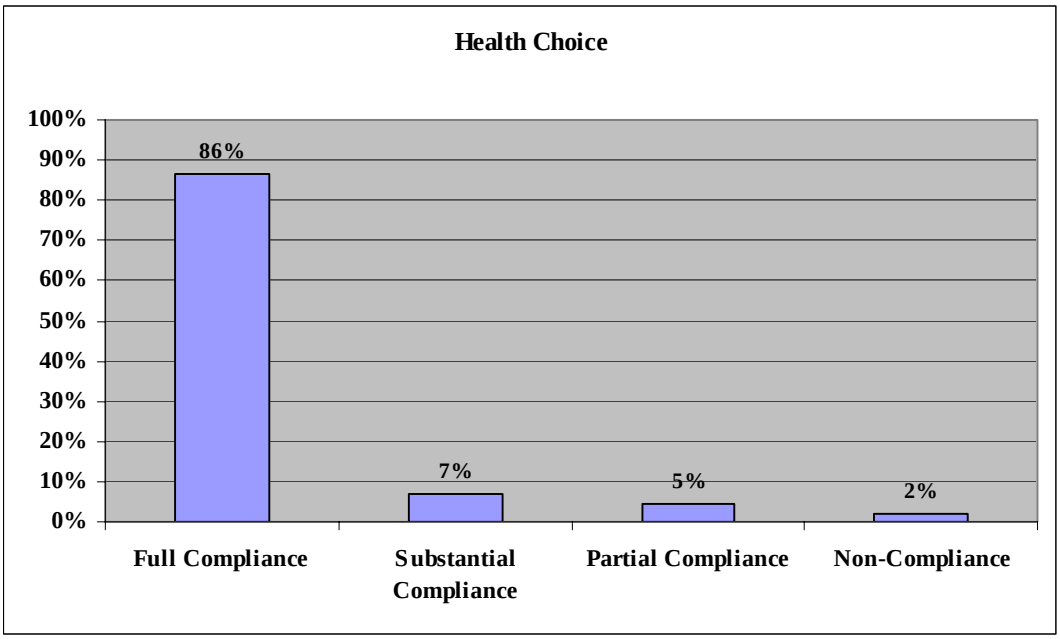
Care1st is encouraged to maintain the level of performance as identified by its own diabetes management PIP for HbA1c testing and lipid profiles. There are no recommendations for the children's oral health PIP because the project was not required to be reported by Care1st.

Health Choice Arizona (Health Choice)

Compliance with Standards (Operational and Financial Review)

Figure 3-9 shows the Health Choice percentage of compliance with the technical standards selected for review in CY 2004-2005. The percentages of the standards in full compliance, substantial compliance, partial compliance, and non-compliance are separately shown.

Figure 3-9—Compliance with Technical Standards *for* Health Choice



The difference between at least partial compliance (the sum of full, substantial, and partial compliance) and full compliance (which can be represented by 98 percent – 86 percent = 12 percent) reflects a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving it. This scenario contrasts with the just 2 percent non-compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving the technical standards), the health plan might make large strides to attain full compliance with relatively little effort. Moving a technical standard from non-compliance to full compliance, however, might require additional educational and other activities.

Figure 3-10 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights both areas of strength and opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on full compliance, substantial compliance, partial compliance, and non-compliance. The figure shows some large compliance differences across the compliance categories.

Figure 3-10—Categorized Levels of Compliance with Technical Standards *for* Health Choice

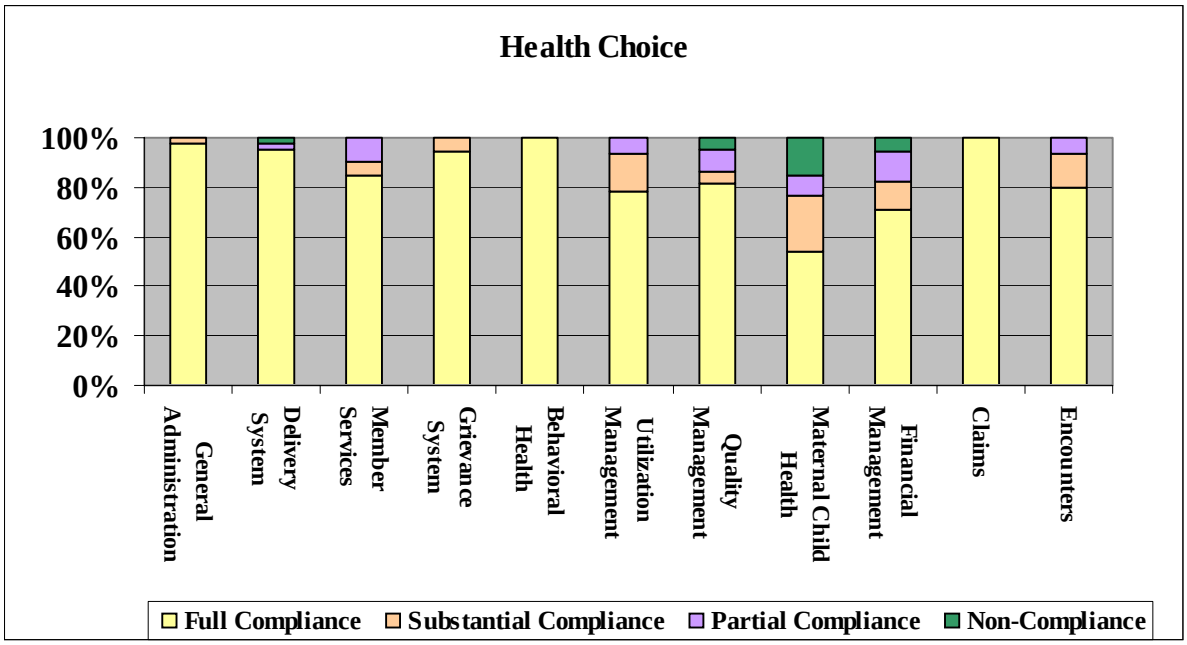


Figure 3-10 shows that all of the technical standards in behavioral health and claims were in full compliance. General administration and grievance system, had only one standard that was not in full compliance, and that standard was in substantial compliance. In contrast, maternal child health showed almost half of the standards at less than full compliance. Overall, only maternal child health was more than 10 percent non-compliant with the technical standards. Overall, 202 were in full compliance, 16 in substantial compliance, 11 in partial compliance, and 5 in non-compliance.

CAPs for Compliance with Standards

Table 3-8 presents each of the categories of technical standards reviewed, the number of CAPs required, each category's percentage of all CAPs, the number of technical standards in each category, and the percentage of technical standards with a CAP for each category.

The table shows that delivery system and utilization management had the greatest opportunities for improvement. Based on the percentage technical standards requiring a CAP, maternal child health, financial management, and encounters also showed opportunities for improvement.

Conversely, Health Choice did not receive a single CAP for behavioral health, making that category a recognized strength. Additionally, general administration, grievance system, and claims each had only one CAP. Overall, 16 percent of the technical standards required a CAP.

Table 3-8—CAP Overview *for* Health Choice				
Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
General Administration	1	3%	38	3%
Delivery System	7	19%	40	18%
Member Services	3	8%	20	15%
Grievance System	1	3%	19	5%
Behavioral Health	0	0%	7	0%
Utilization Management	7	19%	32	22%
Quality Management	4	11%	22	18%
Maternal Child Health	4	11%	13	31%
Financial Management	5	14%	17	29%
Claims	1	3%	11	9%
Encounters	4	11%	15	27%
Total	**37**	**100%**	**234**	**16%**

Performance Measure Review

Table 3-9 shows the separate performance measures for the two most recent time periods, along with the statistical significance level for each of the changes in rates over time. Additionally, the table presents the CY 2004 minimum AHCCCS performance standards and whether a CAP was required.

Table 3-9 shows that performance improved for 12 of the 22 comparable measures between the current and previous measurement time periods, with 7 of the improvements reaching statistical significance. Four of the measures increased by more than 10 percentage points while two measures substantially decreased (i.e., child immunization – 3 HBV – Medicaid and child immunization – 3 HBV – KidsCare). These two immunization measures had exceeded the CY 2004 standard in the prior measurement cycle but dropped 18 and 19 percentage points, respectively, for the current measurement cycle.

The table also shows that fewer than half of the comparable measures (10 of 22) had statistically significant changes during the time periods reviewed herein (i.e., $p \leq .05$). That means that fewer than half of the current rates can be said to differ from the previous rates by more than sampling error alone. Of the 10 measures with a statistically significant change in rates, 7 of the rates were increases and 3 were decreases.

Taken as a whole, performance was essentially flat for the 22 comparable measures. When the changes in these rates are averaged, the result is a mean increase of just .03 percentage points. This finding suggests that performance measures present multiple opportunities for improvement across a wide spectrum of quality indicators.

Table 3-9—Performance Measurement Programs *for* Health Choice					
Performance Measure	Previous Measurement Period**	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Significance Level***	CY 2004 Minimum AHCCCS Performance Standard	CAP Required
Children's Access to PCPs – Medicaid	77.1%	77.6%	p=.287	79%	Yes
Children's Access to PCPs – KidsCare	81.7%	80.7%	p=.430	79%	No
Adults' Preventive/Ambulatory Care	76.0%	76.7%	p=.232	80%	Yes
Well-Child Visits – First 15 Months – Medicaid*	66.4%	70.8%	p=.003	70%	No
Well-Child Visits – 3 to 6 Yrs – Medicaid	53.7%	58.2%	p<.001	55%	No
Well-Child Visits – 3 to 6 Yrs – KidsCare	65.2%	68.0%	p=.368	55%	No
Adolescent Well-Care Visits – Medicaid	30.8%	32.6%	p=.039	32%	No
Adolescent Well-Care Visits – KidsCare	36.3%	39.1%	p=.275	32%	No
Annual Dental Visits – Medicaid	47.2%	58.6%	p<.001	49%	No
Annual Dental Visits – KidsCare	56.9%	69.1%	p<.001	49%	No
Child Immunization – 4 DTP – Medicaid	78.2%	74.2%	p=.118	83%	Yes
Child Immunization – 4 DTP – KidsCare	82.7%	77.5%	p=.390	83%	Yes
Child Immunization – 3 IPV – Medicaid	89.5%	85.5%	p=.043	89%	Yes
Child Immunization – 3 IPV – KidsCare	91.8%	88.8%	p=.486	89%	Yes
Child Immunization – 1 MMR – Medicaid	92.6%	92.0%	p=.706	90%	No
Child Immunization – 1 MMR – KidsCare	92.9%	95.0%	p=.756	90%	No
Child Immunization – 3 HiB – Medicaid	N/A[1]	82.2%	N/A[1]	76%	No
Child Immunization – 3 HiB – KidsCare	N/A[1]	83.8%	N/A[1]	76%	No
Child Immunization – 3 HBV – Medicaid	84.9%	67.2%	p<.001	82%	Yes
Child Immunization – 3 HBV – KidsCare	82.7%	63.8%	p=.004	82%	Yes
Child Immunization – 1 VZV – Medicaid	73.7%	84.6%	p<.001	77%	No
Child Immunization – 1 VZV – KidsCare	78.6%	91.3%	p=.021	77%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – Medicaid	75.7%	70.7%	p=.063	80%	Yes
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare	80.6%	73.8%	p=.275	80%	Yes
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – Medicaid	N/A[1]	50.1%	N/A[1]	70%	Yes
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – KidsCare	N/A[1]	50.0%	N/A[1]	70%	Yes

*There were not enough KidsCare members who met the enrollment criteria to measure a rate for this group.

[1] Current and previous rates are not comparable due to a change in methodology. In the previous measurement, rates for two doses of Hib were reported.

** Children's access to PCPs, adults' preventive/ambulatory care, and child immunizations are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

*** Significance levels ($p \leq .05$) noted in the table demonstrate the statistical significance between performance for the previous measurement period and performance for the current measurement period.

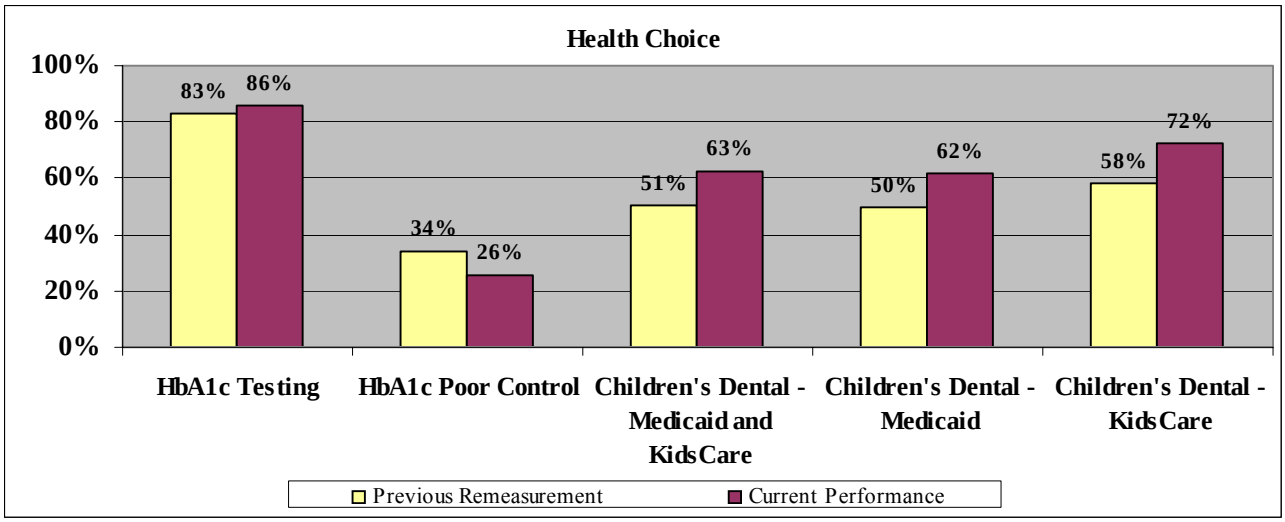
Performance Measures—CAPs

Twelve of the 26 performance measures required a CAP for the current measurement cycle. Five measures without a current CAP, and for which there were data during the previous measurement cycle, would have received a CAP during the previous cycle at the current minimum standard requirement. Conversely, five of the rates that fell would not have received a CAP during the previous measurement cycle but do require one now. On balance, it does not appear that much progress has been made in the area of CAPs for performance measures as assessed by changes to the number of CAPs for comparable measures and against the current minimum AHCCCS performance standards.

Review of PIPs

Figure 3-11 shows that Health Choice improved on all measures associated with PIPs for adult diabetes management and children's oral health. Some of these improvements were substantially large. The HbA1c testing measure is above the current 75th percentile of HEDIS® benchmarks in the previous measurement period and is approaching the 90th percentile benchmark in the current time period. The measures of children's dental health all exceeded the AHCCCS benchmark. In short, the worst-performing measure still did well when compared with national results or the State benchmark.

Figure 3-11—PIP Results *for* Health Choice



Strengths, Opportunities for Improvement, and Recommendations for Health Choice

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

Figure 3-10 shows that general administration, delivery system, grievance system, behavioral health, utilization management, and claims are strengths for Health Choice. Except for utilization management, all of these areas are in at least 95 percent full compliance with the technical standards.

Opportunities for Improvement and Recommendations

Based primarily on the CAPs information shown in Table 3-8, maternal child health, financial management, and encounters represent opportunities for improvement. Each of these areas had more than 25 percent of its technical standards requiring a CAP.

Specific recommendations to improve Health Choice performance can be summarized by the following:

- Health Choice policies, procedures, and processes need to be enhanced to include specific AHCCCS requirements related to:
  - Member transitions, including participation in and discharge from Children's Rehabilitative Services (CRS).
  - Improving performance measure results.
- There were two standards related to provider network monitoring that were out of compliance. Specific areas requiring improvement include:
  - Monitoring provider compliance with AHCCCS appointment standards.
  - Monitoring entities that perform network development and/or management functions.
- Specific areas of medical management that require improvement include ensuring medically necessary supplemental nutrition is provided to eligible members of EPSDT age.
- Other areas of focus for Health Choice were concentrated in management of the plan. These focus areas include:
  - Ensuring Notice of Intended Action forms are presented to members and members are aware of their basic rights.
  - Educating members about their basic rights and ability to seek emergent services without prior authorization.
  - Coordinating care with other related agencies and programs for service.
  - Ensuring that encounter ratios are within AHCCCS standards for performance.
  - Ensuring proper notification is made for third party liability cases.
  - Ensuring the monthly average service level is 75 percent or more.

Performance Measure Review

Strengths

Five of the 12 current areas not requiring a CAP, which had previous data, would have required a CAP during the previous measurement cycle using the same minimum criteria. This finding suggests that improvement took place over the current assessment period and should be viewed as a strength.

Opportunities for Improvement and Recommendations

Overall, there was essentially no statistically significant improvement in the 22 comparable rates. This lack of improvement suggests that in general, there is opportunity for improvement with regard to the performance measure review. For the performance measures, it is recommended that Health Choice focus on methods to improve children's access to PCPs, adults' preventive/ambulatory care, and childhood immunizations. Improving these three areas will help Health Choice meet the State's minimum performance requirements.

Review of PIPs

Strengths

With all of the rates improved between the most recent measurement cycles and diabetes management rates already having been improved over baseline, PIPs are viewed as a strength for Health Choice. Health Choice also did well on its adult diabetes management PIP (which is ending) by both local and national frames of reference. Furthermore, Health Choice has far exceeded the AHCCCS benchmark of 57 percent for children's dental health for both Medicaid and KidsCare members, at 62 percent and 72 percent, respectively. All measures used in both PIPs either approached or exceeded the top 10 percentiles for comparable benchmarks from HEDIS®.

Opportunities for Improvement and Recommendations

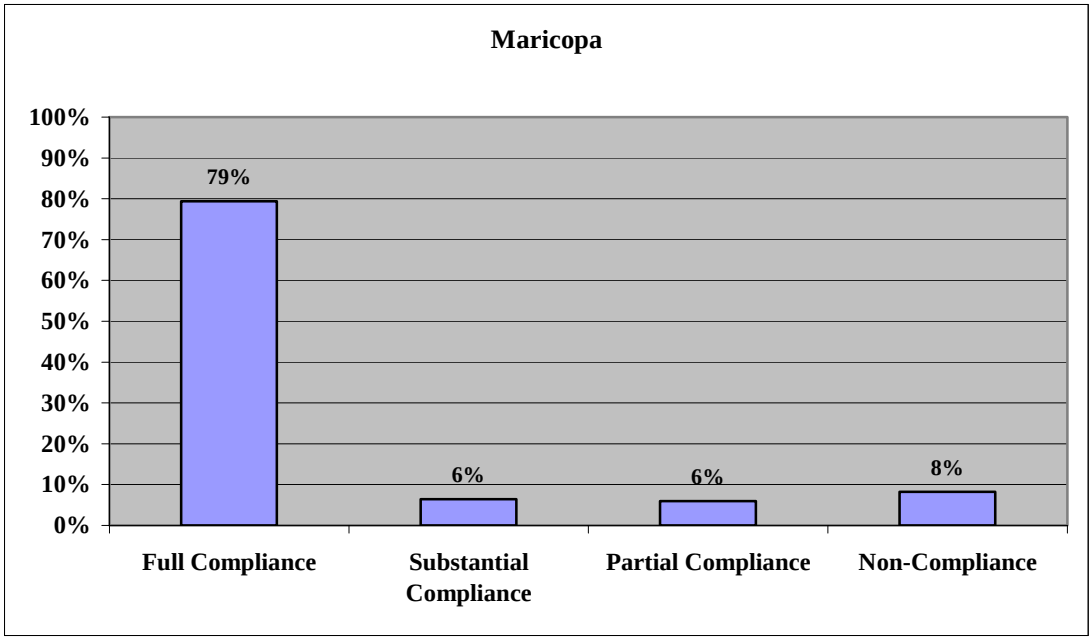
Given the strengths just reported, no opportunities for improvement or recommendations are made for Health Choice's PIPs.

Maricopa Health Plan (Maricopa)

Compliance with Standards (Operational and Financial Review)

Figure 3-12 shows Maricopa's percentage of compliance with the technical standards selected for review in CY 2004-2005. The percentages of the standards in full compliance, substantial compliance, partial compliance, and non-compliance are separately shown.

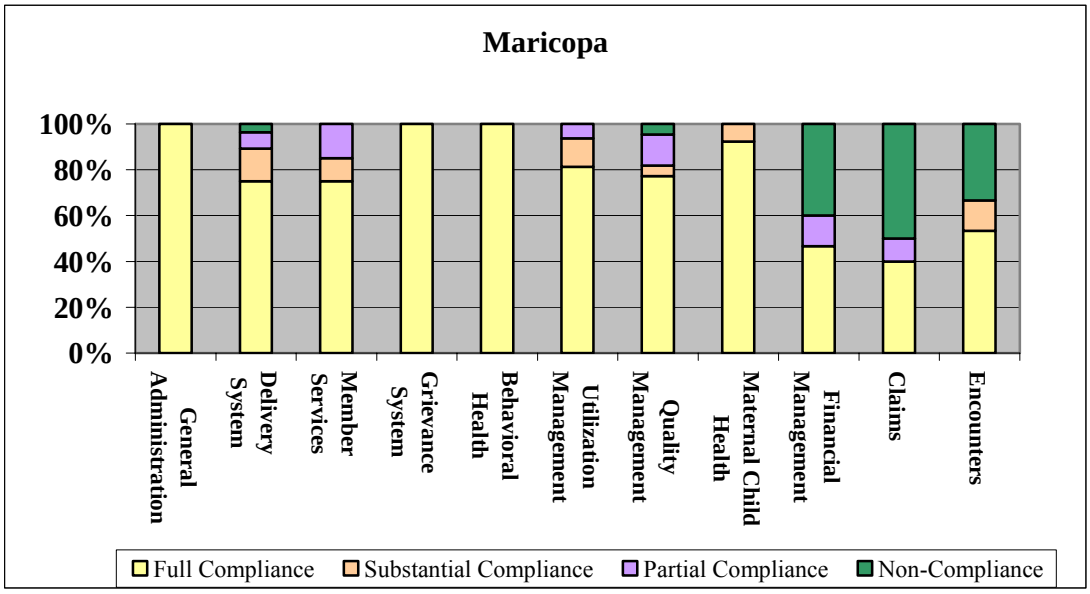
Figure 3-12—Compliance with Technical Standards *for* Maricopa



The difference between at least partial compliance (the sum of full, substantial, and partial compliance) and full compliance (which, with rounding, can be represented by 92 percent – 79 percent = 13 percent) represents a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving it. This scenario contrasts with the 8 percent non-compliance, which indicates that the health plan might not understand the intent of the technical standards. In the first case (i.e., understanding but not fully achieving the technical standards), the health plan might make large strides in attaining full compliance with relatively little effort. Moving a technical standard from non-compliance to full compliance, however, might require additional educational and other activities.

Figure 3-13 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights both areas of strength and opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on full compliance, substantial compliance, partial compliance, and non-compliance. The figure shows some large compliance differences across compliance categories.

Figure 3-13—Categorized Levels of Compliance with Technical Standards *for* Maricopa



The figure shows that three categories (i.e., general administration, grievance system, and behavioral health) were in full compliance with all of their technical standards. In contrast, financial management, claims, and encounters had large opportunities for improvement. The large areas of non-compliance in these three categories suggest that Maricopa might not understand the State's intent for the separate technical standards. Overall, 173 technical standards were in full compliance, 14 in substantial compliance, 13 in partial compliance, and 18 in non-compliance.

CAPs for Compliance with Standards

Table 3-10 presents each of the categories of technical standards reviewed, the number of CAPs required, each category's percentage of all CAPs, the number of technical standards in each category, and the percentage of technical standards with a CAP for each category.

The table shows that, based on the number of CAPs, financial management and encounters had the greatest opportunities for improvement. Claims also had an opportunity for improvement, with 60 percent of technical standards in that category requiring CAPs.

Conversely, Maricopa did not receive a single CAP for general administration, grievance system, or behavioral health, making those categories recognized strengths. Additionally, maternal child health received only one CAP. Overall, 19 percent of the technical standards required a CAP.

Table 3-10—CAP Overview *for* Maricopa				
Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
General Administration	0	0%	38	0%
Delivery System	6	14%	28	21%
Member Services	4	10%	20	20%
Grievance System	0	0%	18	0%
Behavioral Health	0	0%	7	0%
Utilization Management	6	14%	32	19%
Quality Management	4	10%	22	18%
Maternal Child Health	1	2%	13	8%
Financial Management	8	19%	15	53%
Claims	6	14%	10	60%
Encounters	7	17%	15	47%
Total	**42**	**100%**	**218**	**19%**

Performance Measure Review

Table 3-11 shows the separate performance measures for the two most recent time periods, along with the statistical significance level for each of the changes in rates over time. Additionally, the table presents the CY 2004 minimum AHCCCS performance standards and whether a CAP was required.

The table shows that performance improved for 14 of the 22 comparable measures between the current and previous measurement periods. Eight of the measures declined between measurement cycles. Two measures of childhood immunizations (i.e., child immunization – 4 DTP – KidsCare and child immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare) increased by about 16 percent. Annual dental visits – KidsCare had the largest decline, decreasing by nearly 12 percentage points.

Four of the measures not requiring a CAP this measurement cycle would have required one in the previous measurement cycle using the same minimum criteria. This finding suggests substantive improvement in these four measures. Overall, the average improvement for the 22 comparable rates was 4 percent.

The rates for 11 of the 22 comparable measures changed to a statistically significant degree. Of these 11 rates, 9 were improved between the two measurement cycles. The other 11 measures were statistically unchanged, with p-values being greater than 0.05. Overall, where statistically significant change took place, it was in the direction of improvement for Maricopa.

Table 3-11—Performance Measurement Programs *for* Maricopa					
Performance Measure	Previous Measurement Period**	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Significance Level***	CY 2004 Minimum AHCCCS Performance Standard	CAP Required
Children's Access to PCPs – Medicaid	52.7%	66.5%	p<.001	79%	Yes
Children's Access to PCPs – KidsCare	54.5%	68.8%	p<.001	79%	Yes
Adults' Preventive/Ambulatory Care	63.2%	68.8%	p<.001	80%	Yes
Well-Child Visits – First 15 Months – Medicaid*	66.3%	62.7%	p=.060	70%	Yes
Well-Child Visits – 3 to 6 Yrs – Medicaid	49.7%	54.2%	p<.001	55%	Yes
Well-Child Visits – 3 to 6 Yrs – KidsCare	60.5%	59.4%	p=.769	55%	No
Adolescent Well-Care Visits – Medicaid	23.9%	24.7%	p=.401	32%	Yes
Adolescent Well-Care Visits – KidsCare	28.5%	27.4%	p=.732	32%	Yes
Annual Dental Visits – Medicaid	44.0%	37.9%	p<.001	49%	Yes
Annual Dental Visits – KidsCare	62.4%	50.9%	p<.001	49%	No
Child Immunization – 4 DTP – Medicaid	78.4%	90.1%	p<.001	83%	No
Child Immunization – 4 DTP – KidsCare	77.1%	93.1%	p=.013	83%	No
Child Immunization – 3 IPV – Medicaid	93.7%	96.2%	p=.164	89%	No
Child Immunization – 3 IPV – KidsCare	95.7%	94.8%	p=1.00	89%	No
Child Immunization – 1 MMR – Medicaid	93.7%	96.2%	p=.164	90%	No
Child Immunization – 1 MMR – KidsCare	94.3%	93.1%	p=1.00	90%	No
Child Immunization – 3 HiB – Medicaid	N/A[1]	92.0%	N/A[1]	76%	No
Child Immunization – 3 HiB – KidsCare	N/A[1]	93.1%	N/A[1]	76%	No
Child Immunization – 3 HBV – Medicaid	86.4%	90.9%	p=.083	82%	No
Child Immunization – 3 HBV – KidsCare	87.1%	89.7%	p=.660	82%	No
Child Immunization – 1 VZV – Medicaid	85.9%	94.3%	p=.001	77%	No
Child Immunization – 1 VZV – KidsCare	88.6%	86.2%	p=.687	77%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – Medicaid	74.4%	88.2%	p<.001	80%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare	75.7%	91.4%	p=.019	80%	No
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – Medicaid	N/A[1]	77.6%	N/A[1]	70%	No
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – KidsCare	N/A[1]	84.5%	N/A[1]	70%	No

*There were not enough KidsCare members who met the enrollment criteria to measure a rate for this group.

[1] Current and previous rates are not comparable due to a change in methodology. In the previous measurement, rates for two doses of Hib were reported.

** Children's access to PCPs, adults' preventive/ambulatory care, and child immunizations are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

*** Significance levels ($p \leq .05$) noted in the table demonstrate the statistical significance between performance for the previous measurement period and performance for the current measurement period.

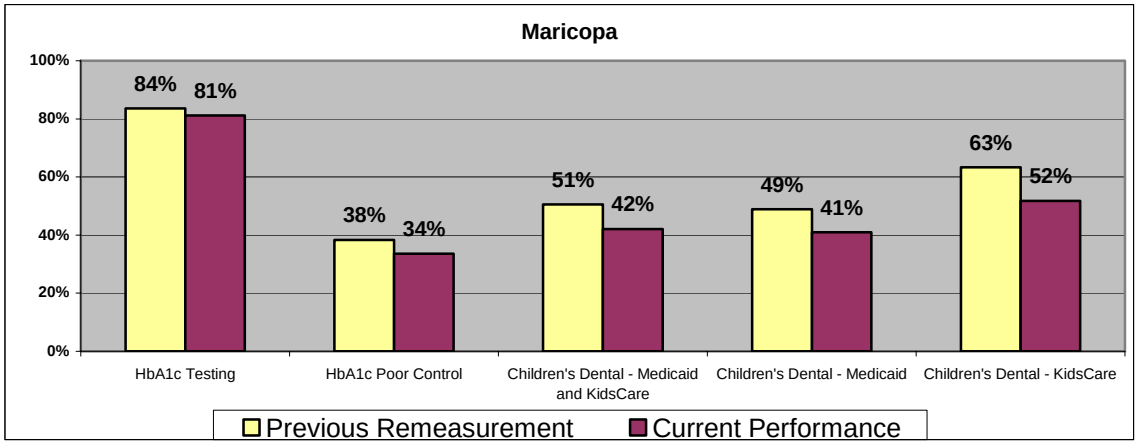
Performance Measures—CAPs

Eight performance measures required a CAP for Maricopa during the current measurement cycle. All eight would have also required a CAP based on the same minimum AHCCCS performance standard during the previous measurement cycle. Of the measures not requiring a CAP during the current measurement cycle, four showed important improvement due to being below the CY 2004 minimum AHCCCS performance standard during the previous measurement cycle.

Review of PIPs

With the exception of HbA1c Poor Control, which showed a relative improvement of about 12 percent (about 4 percentage points), Figure 3-14 shows a decline in PIP quality measure rates for Maricopa both for adult diabetes management (i.e., HbA1c testing) and for children's oral health (i.e., both dental measures for Medicaid and KidsCare). The decreases in children's oral health measures were about 17 percent. Nonetheless, the health plan demonstrated improvement from the baseline measurement to the first remeasurement for adult diabetes management.

Figure 3-14—PIP Results *for* Maricopa



Strengths, Opportunities for Improvement, and Recommendations for Maricopa

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

Figure 3-13 shows that general administration, grievance system, behavioral health, and maternal child health are strengths for Maricopa. Except for maternal child health, all of these areas were 100 percent in full compliance with the technical standards. Maternal child health was 92 percent in full compliance with the remaining 8 percent of standards in substantial compliance.

Opportunities for Improvement and Recommendations

Financial management, claims, and encounters represent substantial opportunities for improvement as shown in Table 3-10 and Figure 3-13. These categories required a CAP for 53, 60, and 47 percent of their technical standards, respectively.

Specific recommendations to improve Maricopa performance can be summarized by the following:

- Maricopa policies, procedures, and processes need to be enhanced to include specific AHCCCS requirements related to:
  - Improving performance measure results.
- There were a number of standards related to provider network monitoring that were out of compliance. Specific areas requiring improvement include:
  - Ensuring that there is appropriate supervision of care by a licensed professional documented in member records.
  - Monitoring and maintaining accountability for all functions that are delegated to other entities.
  - Monitoring provider compliance with national practice guidelines.
  - Monitoring provider compliance with AHCCCS appointment standards.
- Other areas of focus for Maricopa were concentrated in management of the plan. These focus areas include:
  - Ensuring written Notice of Intended Action forms are presented to members as required by AHCCCS.
  - Ensuring that encounter ratios are within AHCCCS standards for performance.
  - Ensuring proper notification is made for third party liability cases.
  - Ensuring that claims are processed and paid within AHCCCS time frames.
  - Ensuring monthly, quarterly, and annual financial reports are complete and timely.
  - Ensuring financial medical expense ratios are within AHCCCS guidelines.
  - Ensuring that there is a sufficient number of staff to monitor the provider network.
  - Ensuring that member materials contain the current member handbook and a comprehensive and current provider directory.
  - Ensuring that members are assigned PCPs within 10 days of assignment by AHCCCS.

Performance Measure Review

Strengths

With their rates increasing by about 16 percentage points each, child immunization – 4 DTP – KidsCare and child immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare are definite strengths in the Maricopa performance measure program. Moreover, 9 of the 11 rates that had a statistically significant change were improved between the two measurement cycles.

Opportunities for Improvement and Recommendations

Annual dental visits – KidsCare had the largest decrease at 12 percentage points, representing the greatest opportunity for improvement in the performance measure review. It is recommended that Maricopa also focus on methods to improve children's access to PCPs, adults' preventive/ambulatory care, and adolescent well-care visits.

Review of PIPs

Strengths

Maricopa demonstrated improvement from baseline to first remeasurement in the diabetes management PIP, and demonstrated sustained performance in the second remeasurement.

Opportunities for Improvement and Recommendations

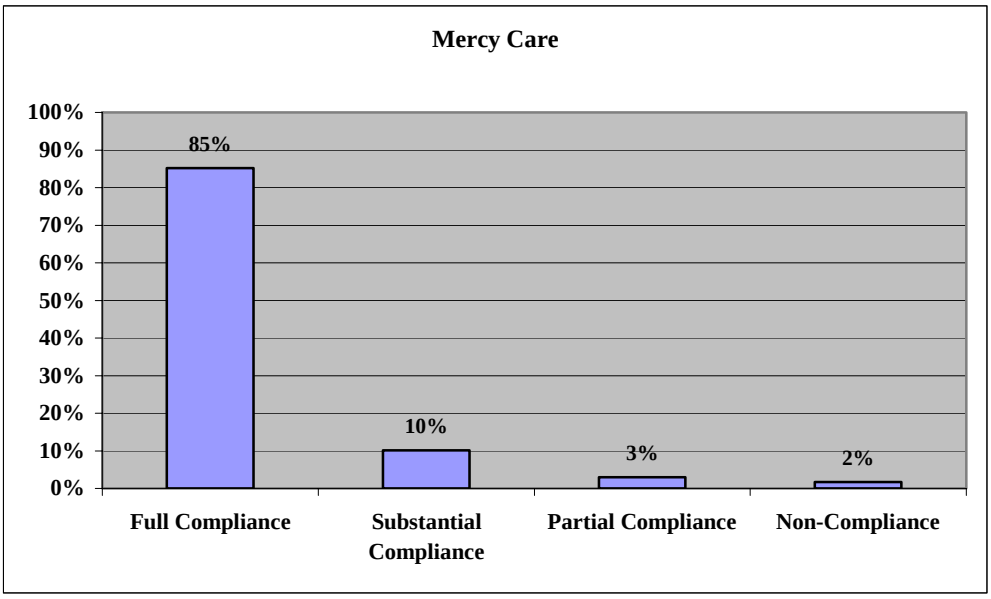
The children's oral health PIP represents an opportunity for improvement for Maricopa because the rates were substantially below the AHCCCS benchmark and dropped substantially during the current measurement cycle.

Mercy Care Plan (Mercy Care)

Compliance with Standards (Operational and Financial Review)

Figure 3-15 shows the Mercy Care percentage of compliance with the technical standards selected for review in CY2004-2005. The percentages of the Standards in full compliance, substantial compliance, partial compliance, and non-compliance are shown separately.

Figure 3-15—Compliance with Technical Standards *for* Mercy Care Plan



The difference between at least partial compliance (the sum of full, substantial, and partial compliance) and full compliance can be represented as 98 percent – 85 percent = 13 percent. This indicates a scenario in which the health plan seems to know the intent of the technical standards but is not achieving it fully. This scenario contrasts with the 2 percent in non-compliance, which indicates the health plan might not understand the intent of the technical standards. In the first case (i.e. understanding but not fully achieving the technical standards), the health plan might make large strides in attaining full compliance with relatively little effort. Moving a technical standard from non-compliance to full compliance, however, might require additional educational and other activities.

Figure 3-16 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights areas of strength and areas where opportunities for improvement exist. In each category, the figure shows the level of compliance with the technical standards based on full compliance, substantial compliance, partial compliance, and non-compliance. The figure shows some large proportional compliance differences across the various categories.

Figure 3-16—Categorized Levels of Compliance with Technical Standards *for* Mercy Care

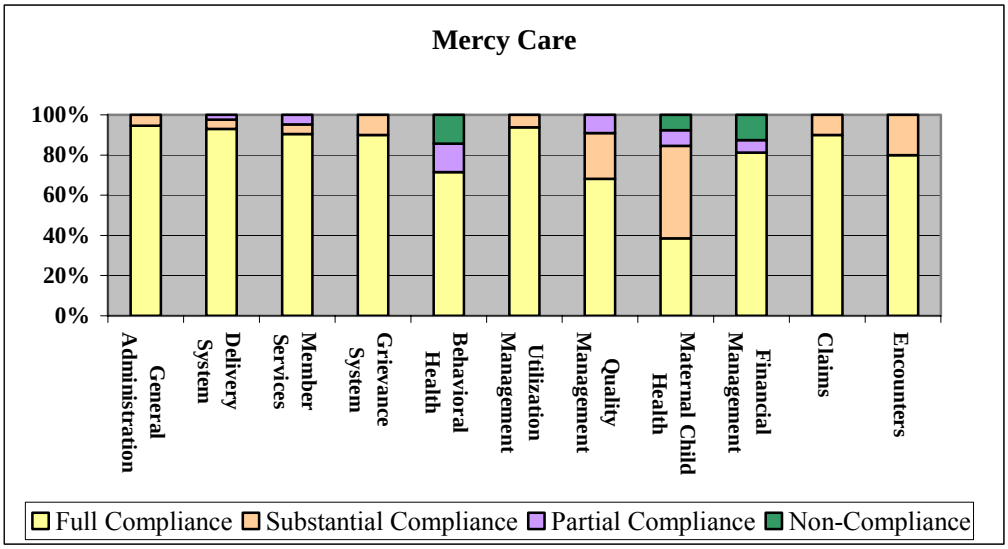


Figure 3-16 shows that all technical standards in general administration, grievance system, utilization management, claims, and encounters are in either full or substantial compliance. Only three of the 11 areas show a non-compliant technical standard. Non-compliant technical standards were less than 2 percent of all technical standards reviewed. Noticeably, maternal child health appears to be an area where the opportunity for improvement is substantial, since only 38 percent of the technical standards are in full compliance. In total, 201 standards were in full compliance, 24 in were in substantial compliance, seven were in partial compliance, and four were in non-compliance.

CAPs for Compliance with Standards

Table 3-12 shows each category of technical standards reviewed, the number of CAPs required, the percentage of CAPs in each category, the number of technical standards in each category, and the percentage of technical standards for each category with a CAP.

The table shows that, proportional to the number of CAPs, delivery system, quality management, and maternal child health present the greatest opportunities for improvement. As a percentage of all of the standards, financial management and encounters also present opportunities for improvement.

Conversely, Mercy Care received only one CAP each for general administration, behavioral health, and claims, making these categories recognized strengths. Additionally, member services, grievance system, and utilization management received only two CAPs each. Overall, 17 percent of the technical standards required a CAP.

Table 3-12—CAP Overview *for* Mercy Care				
Categories of Technical Standards	**Number of CAPs**	**Percent of Total CAPs**	**Total Number of Standards**	**CAPs as a Percent of Standards**
General Administration	1	3%	37	3%
Delivery System	10	26%	43	23%
Member Services	2	5%	21	10%
Grievance System	2	5%	20	10%
Behavioral Health	1	3%	7	14%
Utilization Management	2	5%	32	6%
Quality Management	8	21%	22	36%
Maternal Child Health	6	15%	13	46%
Financial Management	3	8%	16	19%
Claims	1	3%	10	10%
Encounters	3	8%	15	20%
Total	**39**	**100%**	**236**	**17%**

Performance Measure Review

Table 3-13 shows the performance measures for the most recent two time periods (first two columns), along with the statistical significance level for each of the changes in rates over time. Additionally, the table presents the CY 2004 Minimum AHCCCS Performance Standard and whether a CAP was required.

The table shows that performance improved for 21 of the 22 measures that could be compared between the current and previous measurement time periods. Only one measure showed a decline. Child Immunization – 4 DTP – KidsCare showed the largest increase at 15.4 percentage points.

Of the 21 improved rates, 19 showed statistically significant changes. For the three comparable rates whose changes were not statistically significant over time, two posted small gains while one posted a small decline.

Overall, the average change in rates saw an increase of more than 6 percentage points across the 22 comparable measures. Together with earlier findings, these results suggest a pattern of overall improvement for Mercy Care. Moreover, the relative lack of CAPs for this review area is further evidence of Mercy Care's strength in the performance measure review.

Table 3-13—Performance Measurement Programs *for* Mercy Care					
Performance Measure	Previous Measurement Period**	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Significance Level***	CY 2004 Minimum AHCCCS Performance Standard	CAP Required
Children's Access to PCPs – Medicaid	79.2%	79.1%	p=.751	79%	No
Children's Access to PCPs – KidsCare	81.2%	83.0%	p=.014	79%	No
Adults Preventive/Ambulatory Care	78.4%	79.8%	p<.001	80%	Yes
Well-Child Visits – First 15 Months – Medicaid*	67.4%	69.6%	p=.015	70%	Yes
Well-Child Visits – 3 to 6 Yrs – Medicaid	49.8%	56.7%	p<.001	55%	No
Well-Child Visits – 3 to 6 Yrs – KidsCare	52.3%	62.5%	p<.001	55%	No
Adolescent Well-Care Visits – Medicaid	30.2%	32.5%	p<.001	32%	No
Adolescent Well-Care Visits – KidsCare	35.6%	40.0%	p=.002	32%	No
Annual Dental Visits – Medicaid	50.7%	56.2%	p<.001	49%	No
Annual Dental Visits – KidsCare	62.1%	68.2%	p<.001	49%	No
Child Immunization – 4 DTP – Medicaid	77.7%	84.9%	p<.001	83%	No
Child Immunization – 4 DTP – KidsCare	74.9%	90.3%	p<.001	83%	No
Child Immunization – 3 IPV – Medicaid	90.5%	92.0%	p=.200	89%	No
Child Immunization – 3 IPV – KidsCare	89.4%	94.9%	p=.028	89%	No
Child Immunization – 1 MMR – Medicaid	92.3%	93.6%	p=.205	90%	No
Child Immunization – 1 MMR – KidsCare	91.0%	95.9%	p=.036	90%	No
Child Immunization – 3 HiB – Medicaid	N/A[1]	87.5%	N/A[1]	76%	No
Child Immunization – 3 HiB – KidsCare	N/A[1]	90.8%	N/A[1]	76%	No
Child Immunization – 3 HBV – Medicaid	81.9%	89.6%	p<.001	82%	No
Child Immunization – 3 HBV – KidsCare	79.2%	89.9%	p=.002	82%	No
Child Immunization – 1 VZV – Medicaid	75.3%	83.2%	p<.001	77%	No
Child Immunization – 1 VZV – KidsCare	77.3%	89.4%	p<.001	77%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – Medicaid	75.5%	82.5%	p<.001	80%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare	71.4%	85.7%	p<.001	80%	No
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – Medicaid	N/A[1]	74.5%	N/A[1]	70%	No
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – KidsCare	N/A[1]	77.4%	N/A[1]	70%	No

*There were not enough KidsCare members who met the enrollment criteria to measure a rate for this group.

[1] Current and previous rates are not comparable due to a change in methodology. In the previous measurement, rates for two doses of Hib were reported.

** Children's access to PCPs and adults' access to preventive/ambulatory care, and child immunizations are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

*** Significance levels ($p \leq .05$) noted in the table demonstrate the statistical significance between the performance for the previous measurement period and performance for the current measurement period.

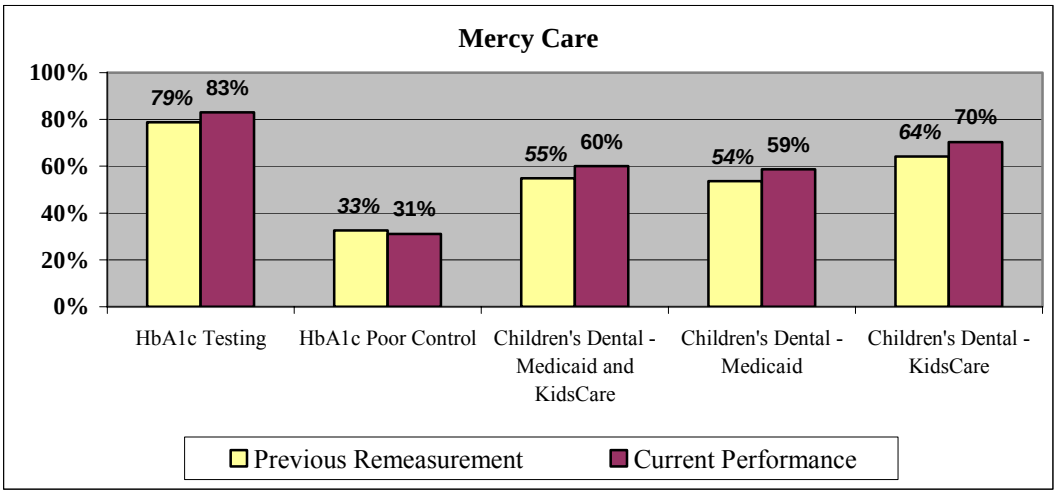
Performance Measures—CAPs

Only two CAPs were required of Mercy Care for the performance measures. Both measures were less than one-half of a percentage point from meeting the Minimum AHCCCS Performance Standard. Importantly, 10 of the performance standards that do not currently require a CAP would have required one during the previous measurement cycle if the criteria of the current measurement cycle were used.

Review of PIPs

All of Mercy Care's PIP measures in Figure 3-17 showed improvement between measurement cycles, although the amounts tended to be modest. Nonetheless, children's oral health showed statistically significant improvement (about 9 percent overall) relative to the rate's prior values and was above the AHCCCS benchmark of 57 percent. The HbA1c poor control measure is a reverse measure for which lower values are better; therefore, the lower rate shown for the current measurement period represents improvement in the measure's rate.

Figure 3-17—PIP Results *for* Mercy Care



Strengths, Opportunities for Improvement, and Recommendations for Mercy Care

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

Figure 3-16 shows that general administration, delivery system, member services, grievance system, utilization management, claims, and encounters are relative strengths for Mercy Care. All are at least 95 percent in substantial compliance with the technical standards.

Opportunities for Improvement and Recommendations

Based primarily on Table 3-12 for the CAPs but also shown in Figure 3-16, quality management and maternal child health represent opportunities for improvement. These categories show that 36 percent and 46 percent of their technical standards, respectively, required a CAP. Specifically, recommendations to improve performance by Mercy Care can be summarized by the following:

- Mercy Care policies, procedures, and processes need to be enhanced to include specific AHCCCS requirements related to:
  - Improving performance measure results.
- There were two standards related to provider network monitoring that were out of compliance. Specific areas requiring improvement include:
  - Ensuring providers maintain comprehensive medical records and include required information.
  - Ensuring that providers respond to requests for information regarding behavioral health services.
- Specific areas of medical management that require improvement include ensuring medically necessary supplemental nutrition is provided to eligible members of EPSDT age, and monitoring member compliance with prenatal care within the prescribed time frames.
- Other areas of focus for Mercy Care were concentrated in management of the plan. These focus areas include:
  - Ensuring proper notification is made for third party liability cases.
  - Ensuring the monthly average service level is 75 percent or more.
  - Ensuring provisional credentialing meets AHCCCS-required timelines.
  - Ensuring that provider subcontracts contain required information.

Performance Measure Review

Strengths

With their rates increasing by 15 and 14 percentage points, respectively, child immunization (4 DTP—KidsCare) and child immunization [DTP, IPV, & MMR (4:3:1 series)—KidsCare] represent strengths for Mercy Care. The rate for children's access to PCPs—Medicaid was the only rate that decreased between the two most recent measurement cycles. However, the rate fell slightly from 79.2 percent to 79.1 percent and still was higher than the 79 percent Minimum AHCCCS Performance Standard.

Opportunities for Improvement and Recommendations

Although the rates increased for both measures, adults' preventive/ambulatory care and well-child visits—first 15 months—Medicaid required CAPs for the current measurement cycle. These rates represent the only opportunities for improvement for the performance measure review in this report. The recommendation is that Mercy Care focus on methods to improve rates for adults'

preventive/ambulatory care and well-child visits—first 15 months—Medicaid. Improvement in these two rates will help Mercy Care meet the State's minimum performance requirements.

Review of PIPs

Strengths

All of the PIP rates improved during the current measurement cycle, in addition to the adult diabetes management rates improving between the baseline and first remeasurement cycles. The current rates for the two adult diabetes measures (i.e., HbA1c testing and HbA1c poor control) were both seen as relatively high when compared with HEDIS® national benchmarks. HbA1c was at approximately the 75th percentile while HbA1c poor control was better than the top 10 percentile mark. Both measures of children's dental visits were higher than the AHCCCS benchmark. Together, these findings suggest that PIPs represent a strength for Mercy Care's quality program.

Opportunities for Improvement and Recommendations

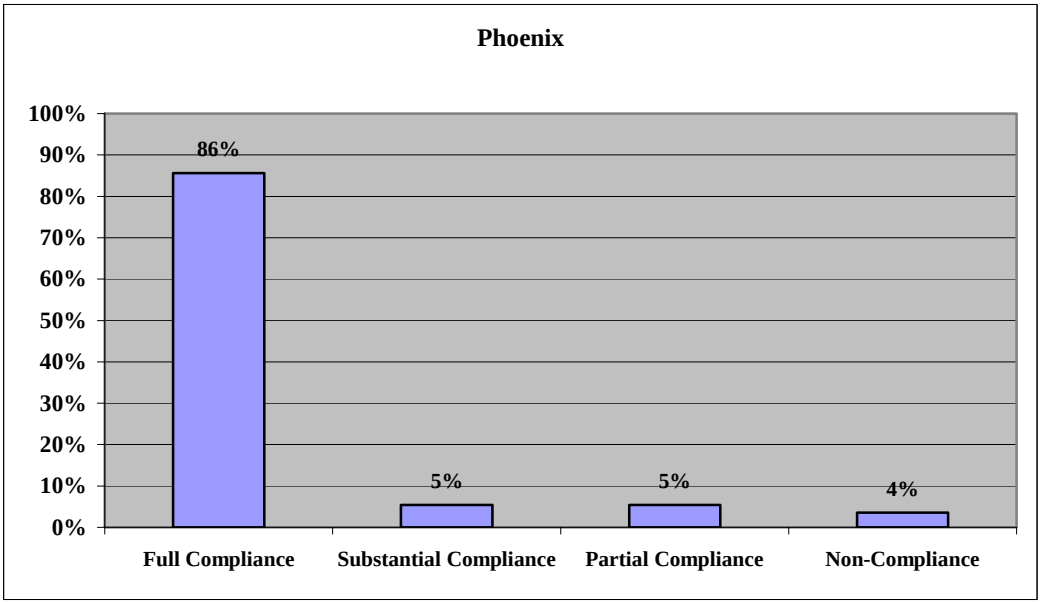
There are no recommendations at this time for Mercy Care's PIPs. The adult diabetes management project is now closed and the children's dental health project appears to be doing well.

Phoenix Health Plan (Phoenix)

Compliance with Standards (Operational and Financial Review)

Figure 3-18 shows Phoenix Health Plan's percentage of compliance with the technical standards reviewed in CY2004-2005. The percentages of the standards in full compliance, substantial compliance, partial compliance, and non-compliance are shown separately.

Figure 3-18—Compliance with Technical Standards *for* Phoenix



The difference between at least partial compliance (the sum of full compliance, substantial compliance, and partial compliance) and full compliance can be represented as 96 percent – 86 percent = 10 percent. This indicates a scenario in which the health plan seems to know the intent of the technical standards but is not fully achieving it. This scenario contrasts with the 4 percent in non-compliance, which indicates the health plan may not understand the intent of the technical standards. In the first case (i.e. understanding but not fully achieving the technical standards), the health plan might make large strides in attaining full compliance with relatively little effort. Moving a technical standard from non-compliance to full compliance, however, might require additional educational and other activities.

Figure 3-19 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights areas of strength and areas with more opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards based on full compliance, substantial compliance, partial compliance, and non-compliance. The figure also shows some large proportional compliance differences across the various categories.

Figure 3-19—Categorized Levels of Compliance with Technical Standards *for* Phoenix

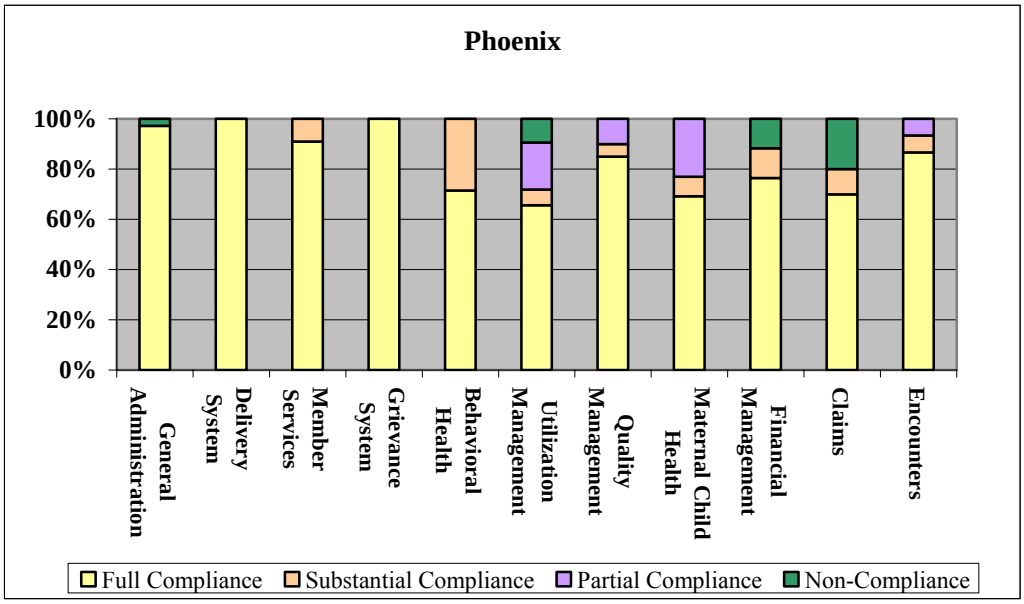


Figure 3-19 shows that all of the technical standards in delivery system, member services, grievance system, and behavioral health are in either full or substantial compliance. Four of the 11 areas show non-compliance; non-compliant technical standards account for less than 4 percent of all technical standards under review. Noticeably, utilization management, financial management, and claims appear to be area where relative opportunities for improvement exist. In total, 191 of the standards were in full compliance, 12 were in substantial compliance, 12 were in partial compliance, and eight were in non-compliance.

CAPs for Compliance with Standards

Table 3-14 shows each of the categories of technical standards reviewed, the number of CAPs required, the percentage of all CAPs in each category, the number of technical standards in each category, and the percentage of technical standards for each category with a CAP.

The table shows that, proportional to the number of CAPs, utilization management represents the greatest opportunity for improvement, receiving 31 percent of the total number of CAPs. However, as a percentage of all standards, behavioral health, maternal child health, financial management, and claims also present opportunities for improvement during the current review cycle.

Conversely, Phoenix Health Plan did not receive a single CAP for delivery system or grievance system, making those categories recognized strengths. Additionally, general administration, member services, behavioral health, and encounters received only two CAPs each. Overall, 16 percent of the technical standards required a CAP.

Table 3-14—CAP Overview *for* Phoenix				
Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
General Administration	2	6%	36	6%
Delivery System	0	0%	31	0%
Member Services	2	6%	22	9%
Grievance System	0	0%	20	0%
Behavioral Health	2	6%	7	29%
Utilization Management	11	31%	32	34%
Quality Management	3	9%	20	15%
Maternal Child Health	5	14%	13	38%
Financial Management	4	11%	17	24%
Claims	4	11%	10	40%
Encounters	2	6%	15	13%
Total	**35**	**100%**	**223**	**16%**

Performance Measure Review

Table 3-15 shows the performance measures for the most recent two time periods (first two columns), along with the statistical significance level for each of the changes in rates over time. Additionally, the table presents the CY 2004 Minimum AHCCCS Performance Standard and whether a CAP was required.

The table shows that 18 of the 22 measures that could be compared improved between the two time periods. Child immunization—1 VZV for both Medicaid and KidsCare increased the most, at 7 percentage points. Well-child visits—first 15 months—Medicaid decreased the most, at 6 percentage points.

Of the 18 rates that improved, five showed statistically significant changes. This suggests that 13 rates could be showing improvement because of a sampling error rather than a "true" increase. For the four rates that showed a decline, only one met statistical significance. This finding also suggests that three of the rates showing a decline did so due to sampling error and may not be a "true" decrease.

Overall, the average change in rates saw an increase of 1.6 percentage points across the 22 comparable measures. Together with earlier findings, these results suggest a pattern that is slightly better than flat for Phoenix Health Plan's performance measure review.

Table 3-15—Performance Measurement Programs *for* Phoenix					
Performance Measure	Previous Measurement Period**	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Significance Level***	CY 2004 Minimum AHCCCS Performance Standard	CAP Required
Children's Access to PCPs – Medicaid	74.9%	77.1%	p<.001	79%	Yes
Children's Access to PCPs – KidsCare	76.7%	78.7%	p=.068	79%	Yes
Adults' Preventive/Ambulatory Care	75.6%	77.8%	p<.001	80%	Yes
Well-Child Visits – First 15 Months – Medicaid*	68.0%	62.4%	p<.001	70%	Yes
Well-Child Visits – 3 to 6 Yrs – Medicaid	52.0%	53.7%	p=.056	55%	Yes
Well-Child Visits – 3 to 6 Yrs – KidsCare	64.8%	60.9%	p=.143	55%	No
Adolescent Well-Care Visits – Medicaid	26.9%	28.2%	p=.068	32%	Yes
Adolescent Well-Care Visits – KidsCare	35.3%	32.4%	p=.159	32%	No
Annual Dental Visits – Medicaid	50.0%	56.3%	p<.001	49%	No
Annual Dental Visits – KidsCare	63.9%	69.2%	p<.001	49%	No
Child Immunization – 4 DTP – Medicaid	84.6%	86.6%	p=.391	83%	No
Child Immunization – 4 DTP – KidsCare	92.9%	93.5%	p=.865	83%	No
Child Immunization – 3 IPV – Medicaid	93.3%	94.3%	p=.510	89%	No
Child Immunization – 3 IPV – KidsCare	96.9%	97.8%	p=1.00	89%	No
Child Immunization – 1 MMR – Medicaid	94.0%	94.3%	p=.823	90%	No
Child Immunization – 1 MMR – KidsCare	99.0%	97.8%	p=.611	90%	No
Child Immunization – 3 HiB – Medicaid	N/A[1]	91.2%	N/A[1]	76%	No
Child Immunization – 3 HiB – KidsCare	N/A[1]	94.6%	N/A[1]	76%	No
Child Immunization – 3 HBV – Medicaid	90.8%	92.0%	p=.514	82%	No
Child Immunization – 3 HBV – KidsCare	91.8%	95.7%	p=.280	82%	No
Child Immunization – 1 VZV – Medicaid	78.8%	86.1%	p=.004	77%	No
Child Immunization – 1 VZV – KidsCare	88.8%	95.7%	p=.079	77%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – Medicaid	82.8%	85.8%	p=.215	80%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare	91.8%	92.4%	p=.887	80%	No
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – Medicaid	N/A[1]	80.9%	N/A[1]	70%	No
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – KidsCare	N/A[1]	88.0%	N/A[1]	70%	No

*There were not enough KidsCare members who met the enrollment criteria to measure a rate for this group.

[1] Current and previous rates are not comparable due to a change in methodology. In the previous measurement, rates for two doses of Hib were reported.

** Children's access to PCPs and adults' access to preventive/ambulatory care, and child immunizations are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

*** Significance levels ($p \leq .05$) noted in the table demonstrate the statistical significance between the performance for the previous measurement period and performance for the current measurement period.

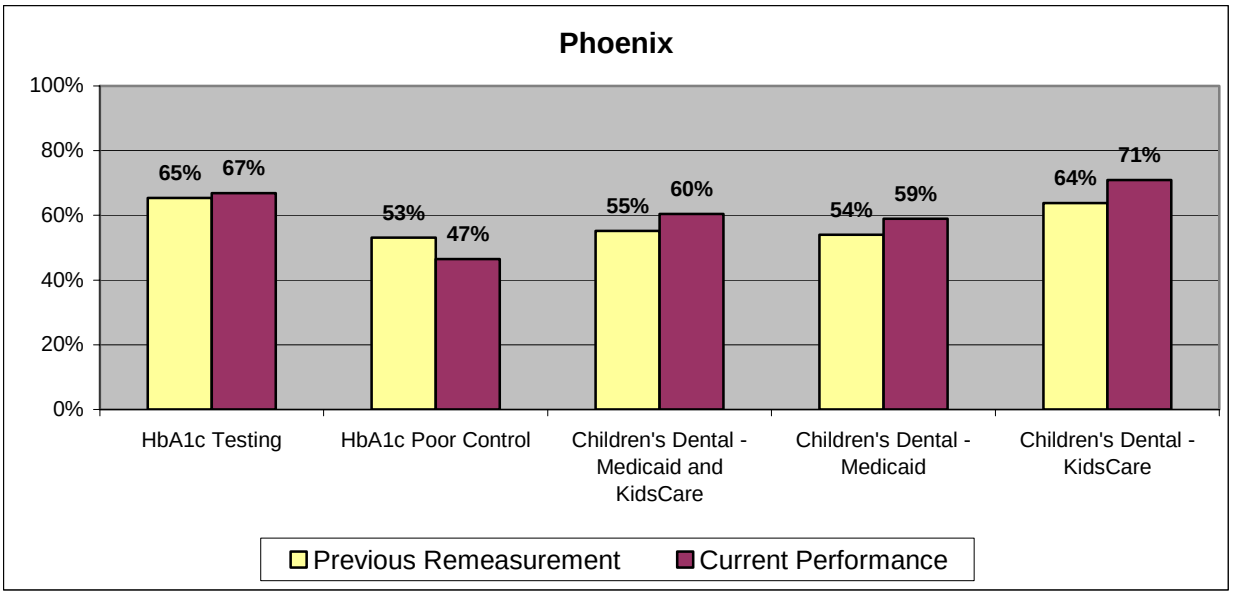
Performance Measures—CAPs

Six CAPs were required for Phoenix Health Plan's performance measure results. Additionally, every performance standard not currently requiring a CAP also would not have required one during the previous measurement cycle using the criteria used during the current measurement cycle. Each measure currently requiring a CAP also would have required a CAP during the previous cycle using the current minimum standard for performance.

Review of PIPs

Figure 3-20 shows that Phoenix Health Plan improved in all measures associated with the PIPs, both for adult diabetes management and for children's oral health. Neither of the two measures under adult diabetes management showed a change sufficient to reach statistical significance beyond the improvements shown between baseline and the first remeasurement cycles. Both of the children's oral health measures showed statistically significant improvement, partly due to the size difference between the diabetes and the oral health eligible populations. The children's dental visits—Medicaid measure improved by a relative 9 percent, whereas the children's dental visits—KidsCare improved by a relative 11 percent. Both children's oral health measures surpassed the AHCCCS benchmark of 57 percent. The HbA1c poor control measure is a reverse measure for which lower values are better; therefore, the lower rate shown for the current measurement period represents improvement in the measure's rate.

Figure 3-20—PIP Results *for* Phoenix



Strengths, Opportunities for Improvement, and Recommendations for Phoenix

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

Figure 3-19 shows that the delivery system and grievance system categories of review are in full compliance with all of their technical standards. Furthermore, member services and behavioral health have all of their technical standards at least in substantial compliance. These four categories therefore, are seen as relative strengths.

Opportunities for Improvement and Recommendations

Based primarily on Table 3-14 for the CAPs but also shown in Figure 3-19, utilization management, behavioral health, maternal child health, financial management, and claims represent opportunities for improvement. Overall, 16 percent of the technical standards required a CAP. Specific recommendations to improve performance by Phoenix can be summarized by the following:

- Phoenix policies, procedures, and processes need to be enhanced to include specific AHCCCS requirements related to:
  - Improving performance measure results.
  - Utilization management and concurrent review for inpatient stays.
  - Member transitions, including participation in and discharge from Children's Rehabilitative Services (CRS).
- There were three standards related to provider network monitoring that were out of compliance. Specific areas requiring improvement include:
  - Monitoring provider compliance with national practice guidelines.
  - Ensuring that emergency services are provided in sufficient amount, duration, and scope.
  - Ensuring member privacy in the process of coordinating care.
- Specific areas of medical management that require improvement include:
  - Ensuring medically necessary supplemental nutrition is provided to eligible members of EPSDT age.
  - Monitoring member compliance with prenatal care within the prescribed time frames.
  - Monitoring health maintenance through disease management programs.
- Other areas of focus for Phoenix were concentrated in management of the plan. These focus areas include:
  - Ensuring proper notification is made for third party liability cases.
  - Ensuring provisional credentialing meets AHCCCS-required timelines.

- Ensuring that claims are processed and paid within AHCCCS time frames.
- Ensuring written Notice of Intended Action forms are presented to members as required by AHCCCS.
- Educating members about their basic rights and ability to seek emergent services without prior authorization.

Performance Measure Review

Strengths

Phoenix Health Plan saw two measures improve by 7 percentage points: child immunization—1 VZV—Medicaid and child immunization—1 VZV—KidsCare. These measures were, therefore, a relative strength among the measures that generally improved by small amounts.

Opportunities for Improvement and Recommendations

Overall, performance was statistically fairly flat. The well-child visits—first 15 months—Medicaid measure decreased by 6 percentage points. This measure represents the largest opportunity for improvement based on its performance during the current review cycle versus the previous one. This measure also represents the greatest opportunity for improvement when compared with the Minimum AHCCCS Performance Standard, at 7.6 percentage points below the standard. The recommendation, therefore, is that Phoenix focus on methods to improve the rates for well-child visits—first 15 months—Medicaid, but also on children's access to PCPs, adults' preventive/ambulatory care, well-child visits—3 to 6 years—Medicaid, and adolescent well-care visits— Medicaid because these rates were also relatively low.

Review of PIPs

Strengths

All of the PIP rates improved during the current measurement cycle. The HbA1c Testing measure was at about the 25th national HEDIS® benchmark. The HbA1c Poor Control measure was at about the national median benchmark. Nonetheless, the health plan demonstrated improvement from the baseline measurement to the first remeasurement for diabetes management. Both measures of children's dental visits were substantively high compared with the AHCCCS benchmark of 57 percent These findings suggest that the children's oral health PIPs represent a strength for Phoenix Health Plan's quality program more so than the adult diabetes management project.

Opportunities for Improvement and Recommendations

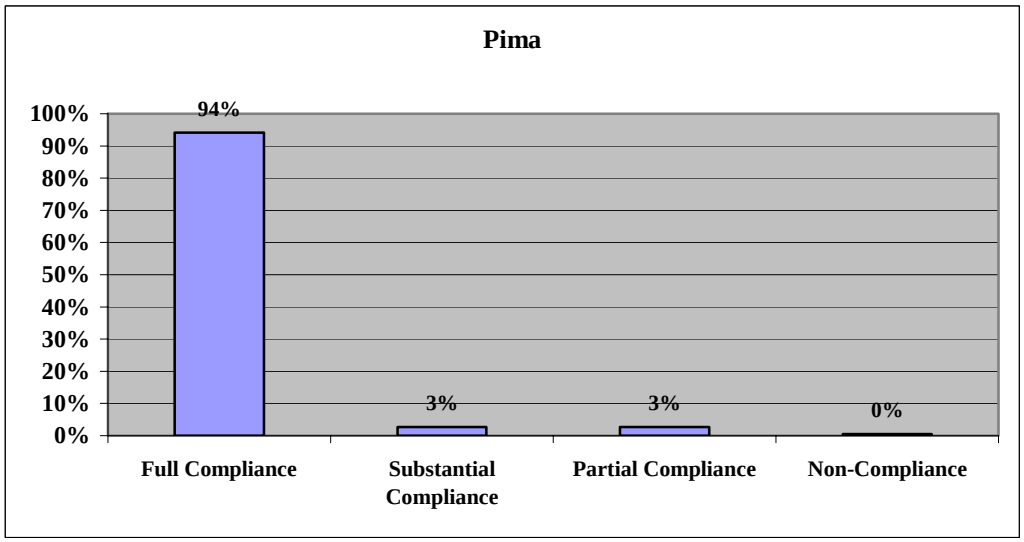
There are no opportunities for improvement presented or recommendations for Phoenix's PIPs because the adult diabetes management project was closed and the children's dental health project was doing well.

Pima Health System (Pima)

Compliance with Standards (Operational and Financial Review)

Figure 3-21 shows the Pima percentage of compliance with the technical standards selected for review in CY2004-2005. The percentages of the standards in full compliance, substantial compliance, partial compliance, and non-compliance are shown separately.

Figure 3-21—Compliance with Technical Standards *for* Pima



Only one technical standard was not in at least partial compliance for Pima. This one standard was under the category of financial management. Pima clearly understands the intent of the standards, showing 94 percent fully compliant and 3 percent each either substantially compliant or partially compliant. Figure 3-22 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights the fact that there are relatively few areas that need opportunities for improvement, especially in comparison to the other health plans reviewed in this report.

Figure 3-22—Categorized Levels of Compliance with Technical Standards *for* Pima

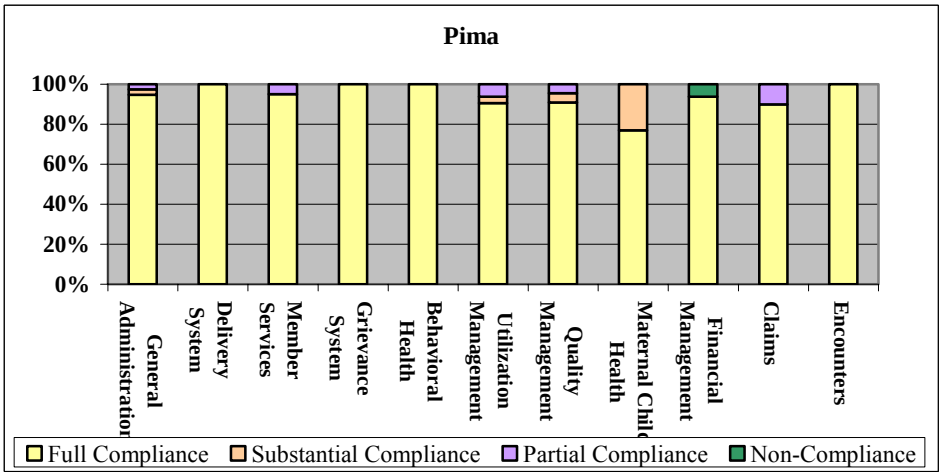


Figure 3-22 shows that all of the technical standards in delivery system, grievance system, behavioral health, and encounters are all in full compliance. Only financial management shows a single non-compliant technical standard. In total, 207 standards were in full compliance, six were in substantial compliance, six were in partial compliance, and one was in non-compliance.

CAPs for Compliance with Standards

Table 3-16 presents each of the categories of technical standards reviewed, the number of CAPs required, the percentage of all CAPs in each category, the number of technical standards in each category, and the percentage of technical standards for each category with a CAP.

The table shows that, proportional to the number of CAPs, general administration, utilization management, quality management, and maternal child health represent the greatest opportunities for improvement, although each category received only two CAPs. As a percentage of all standards, only maternal child health and claims had at least 10 percent CAPs.

Pima received no CAPs for delivery system, behavioral health, or claims, making those categories recognized strengths. Additionally, no category received more than two CAPs, and only 5 percent of the technical standards required a CAP. These findings suggest that compliance with standards is a definite strength for Pima.

Table 3-16—CAP Overview *for* Pima

Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
General Administration	2	17%	38	5%
Delivery System	0	0%	27	0%
Member Services	1	8%	20	5%
Grievance System	1	8%	20	5%
Behavioral Health	0	0%	7	0%
Utilization Management	2	17%	32	6%
Quality Management	2	17%	22	9%
Maternal Child Health	2	17%	13	15%
Financial Management	1	8%	16	6%
Claims	1	8%	10	10%
Encounters	0	0%	15	0%
Total	**12**	**100%**	**220**	**5%**

Performance Measure Review

Table 3-17 shows the performance measures for the most recent two time periods (first two columns), along with the statistical significance level for each of the changes in rates over time. Additionally, the table presents the CY 2004 Minimum AHCCCS Performance Standard and whether a CAP was required.

Table 3-17—Performance Measurement Programs for Pima

Performance Measure	Previous Measurement Period**	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Significance Level***	CY 2004 Minimum AHCCCS Performance Standard	CAP Required
Children's Access to PCPs – Medicaid	79.4%	81.0%	p=.045	79%	No
Children's Access to PCPs – KidsCare	79.7%	80.1%	p=.892	79%	No
Adults' Preventive/Ambulatory Care	75.9%	78.1%	p=.050	80%	Yes
Well-Child Visits – First 15 Months – Medicaid*	78.6%	72.5%	p=.063	70%	No
Well-Child Visits – 3 to 6 Yrs – Medicaid	54.2%	55.5%	p=.590	55%	No
Well-Child Visits – 3 to 6 Yrs – KidsCare	63.2%	62.9%	p=.980	55%	No
Adolescent Well-Care Visits – Medicaid	35.0%	34.8%	p=.909	32%	No
Adolescent Well-Care Visits – KidsCare	53.4%	40.6%	p=.022	32%	No
Annual Dental Visits – Medicaid	46.1%	53.1%	p<.001	49%	No
Annual Dental Visits – KidsCare	63.0%	60.1%	p=.462	49%	No
Child Immunization – 4 DTP – Medicaid	89.3%	88.8%	p=.898	83%	No
Child Immunization – 4 DTP – KidsCare	93.3%	100.0%	p=1.00	83%	No
Child Immunization – 3 IPV – Medicaid	96.6%	92.8%	p=.133	89%	No
Child Immunization – 3 IPV – KidsCare	100.0%	100.0%	p=1.00	89%	No
Child Immunization – 1 MMR – Medicaid	98.3%	94.4%	p=.099	90%	No
Child Immunization – 1 MMR – KidsCare	93.3%	100.0%	p=1.00	90%	No
Child Immunization – 3 HiB – Medicaid	N/A[1]	92.8%	N/A[1]	76%	No
Child Immunization – 3 HiB – KidsCare	N/A[1]	100.0%	N/A[1]	76%	No
Child Immunization – 3 HBV – Medicaid	90.4%	90.4%	p=.999	82%	No
Child Immunization – 3 HBV – KidsCare	100.0%	100.0%	p=1.00	82%	No
Child Immunization – 1 VZV – Medicaid	92.7%	91.2%	p=.645	77%	No
Child Immunization – 1 VZV – KidsCare	93.3%	93.3%	p=1.00	77%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – Medicaid	88.7%	85.6%	p=.424	80%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare	86.7%	100.0%	p=.483	80%	No
Child Immunization – DTP, IPV, MMR, HiB, & HBV (4:3:1:3:3 Series) – Medicaid	N/A[1]	76.8%	N/A[1]	70%	No
Child Immunization – DTP, IPV, MMR, HiB, & HBV (4:3:1:3:3 Series) – KidsCare	N/A[1]	100.0%	N/A[1]	70%	No

*There were not enough KidsCare members who met the enrollment criteria to measure a rate for this group.

[1] Current and previous rates are not comparable due to a change in methodology. In the previous measurement, rates for two doses of Hib were reported.

** Children's access to PCPs and adults' access to preventive/ambulatory care, and child immunizations are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

*** Significance levels ($p \leq .05$) noted in the table demonstrate the statistical significance between the performance for the previous measurement period and performance for the current measurement period.

The table shows that eight of the 22 comparable measures increased between the two time periods, with two additional measures starting and ending at 100 percent. Child immunization—DTP, IPV, & MMR (4:3:1 series)—KidsCare increased the most, at 13 percentage points. Adolescent well-care visits—KidsCare decreased the most, also by 13 percentage points.

Overall performance was statistically flat, averaging an increase of only 0.19 percent between the two most recent review periods. Further evidence of this flat performance is the finding that only four measures changed enough to achieve statistical significance. Of these four, three increased in their rates while one decreased. Nonetheless, the average of all 26 rates shows that Pima was almost 10 percentage points higher than the average of the CY 2004 Minimum AHCCCS Performance Standard.

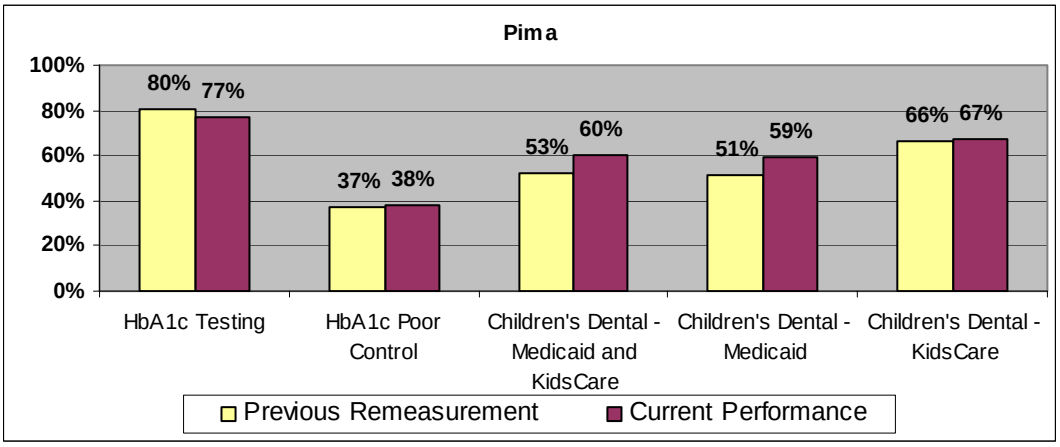
Performance Measures—CAPs

Only one CAP was required for Pima's performance measure results. Additionally, only two of the performance standards not currently requiring a CAP would have required one during the previous measurement cycle using the criteria of the current measurement cycle. From the perspective of achieving the Minimum AHCCCS Performance Standard, Pima has done quite well with the performance measure review. Nonetheless, having attained the minimum standards, Pima might still find it worthwhile to further increase the rates for the performance measures.

Review of PIPs

Figure 3-23 shows that Pima made improvements in measures associated with children's oral health but decreased a small amount for both measures of adult diabetes management (the HbA1c poor control measure is a reverse measure for which lower values are better). HbA1c Testing was about at the median national HEDIS® benchmark and HbA1c poor control was at about the top 25th percentile benchmark at the close of the adult diabetes management PIP. Nonetheless, the health plan demonstrated improvement from the baseline measurement to the first remeasurement for diabetes management. Both measures of children's oral health have already surpassed the AHCCCS benchmark rate of 57 percent.

Figure 3-23—PIP Results *for* Pima



Strengths, Opportunities for Improvement, and Recommendations for Pima

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

Figure 3-22 shows that delivery system, grievance system, behavioral health, and encounters are in full compliance with all of their technical standards. Furthermore, maternal child health shows that all of its technical standards are at least in substantial compliance. These categories of review, therefore, are seen as strengths for Pima.

Opportunities for Improvement and Recommendations

Based primarily on Table 3-16 for the CAPs but also shown in Figure 3-22, general administration, utilization management, quality management, and maternal child health represent opportunities for improvement, although the need for these is somewhat small due to the relatively few CAPs. Specifically, recommendations to improve performance by Pima can be summarized by the following:

- Ensuring interpreter services are available at provider appointments
- Monitoring pharmacy claims to evaluate the prescription benefit program
- Ensuring written Notice of Intended Action forms are presented to members as required by AHCCCS
- Maintaining a process for improving performance measure results
- Training claims personnel
- Ensuring proper notification is made for third party liability cases
- Ensuring call abandonment rates are 5 percent or less

Performance Measure Review

Strengths

Pima showed relatively flat but high performance this review. This flat performance represents an opportunity for improvement, although the relatively high performance (i.e. a strength) is evidenced by Pima receiving only one CAP for the performance measure review—for adults' preventive/ ambulatory care.

Opportunities for Improvement and Recommendations

The recommendation is that Pima focus on methods to improve adults' preventive/ambulatory care rates due to the CAP.

Review of PIPs

Strengths

The adult diabetes management project was closed after appropriate improvement between baseline and the first remeasurement periods was substantively sustained for the second remeasurement. Both measures for children's oral health improved; therefore, independent of the small decreases in rates closing adult diabetes management, the PIPs are viewed as a strength moving forward. This finding is supported by both rates for children's oral health exceeding the AHCCCS benchmark rate.

Opportunities for Improvement and Recommendations

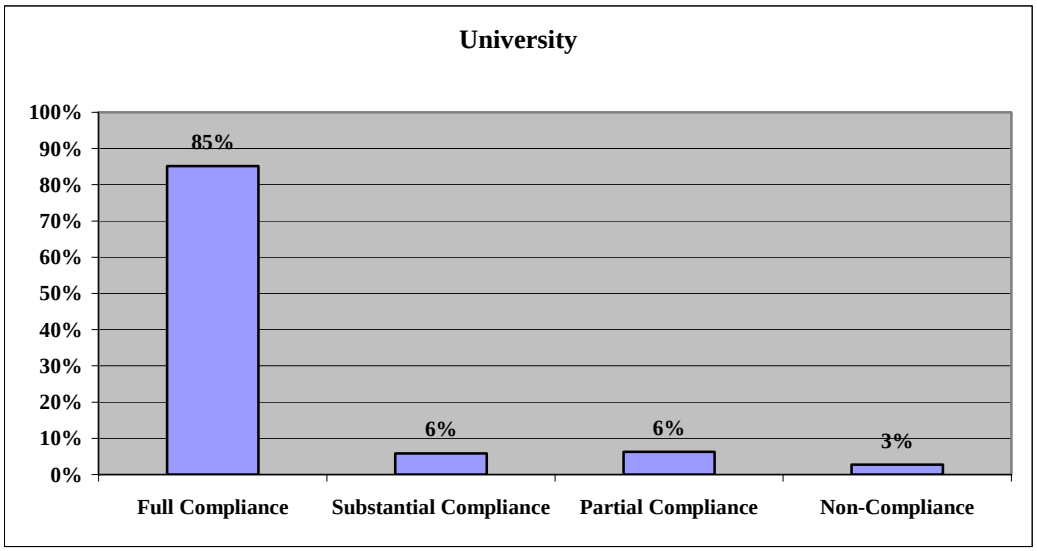
There are no recognized opportunities for improvement or recommendations at this time for Pima's PIPs. The adult diabetes management project was closed and the children's dental health project appeared to be doing well.

University Family Care (University)

Compliance with Standards (Operational and Financial Review)

Figure 3-24 shows University's percentage of compliance with the technical standards selected for review in CY2004-2005. The percentages of the standards in full compliance, substantial compliance, partial compliance, and non-compliance are shown separately.

Figure 3-24—Compliance with Technical Standards *for* University



The difference between at least partial compliance (the sum of full, substantial, and partial compliance) and full compliance can be represented as 97 percent – 85 percent = 12 percent. This indicates a scenario under which the health plan seems to know the intent of the technical standards but is not achieving it fully. This scenario contrasts with the 3 percent of standards in non-compliance, which indicates the health plan may not understand the intent of the technical standards. In the first case (i.e. understanding but not fully achieving the technical standards), the health plan might make large strides to attain full compliance with relatively little effort. Moving a technical standard from non-compliance to full compliance, however, might require additional educational and other activities.

Figure 3-25 shows the extent of compliance for each major area within the technical standards. The figure highlights areas of strength as well as areas with more opportunities for improvement. In each category, the figure shows the level of compliance with the technical standards, based on full compliance, substantial compliance, partial compliance, and non-compliance. Additionally, the figure shows some large proportional compliance differences across the various categories.

Figure 3-25—Categorized Levels of Compliance with Technical Standards *for* University

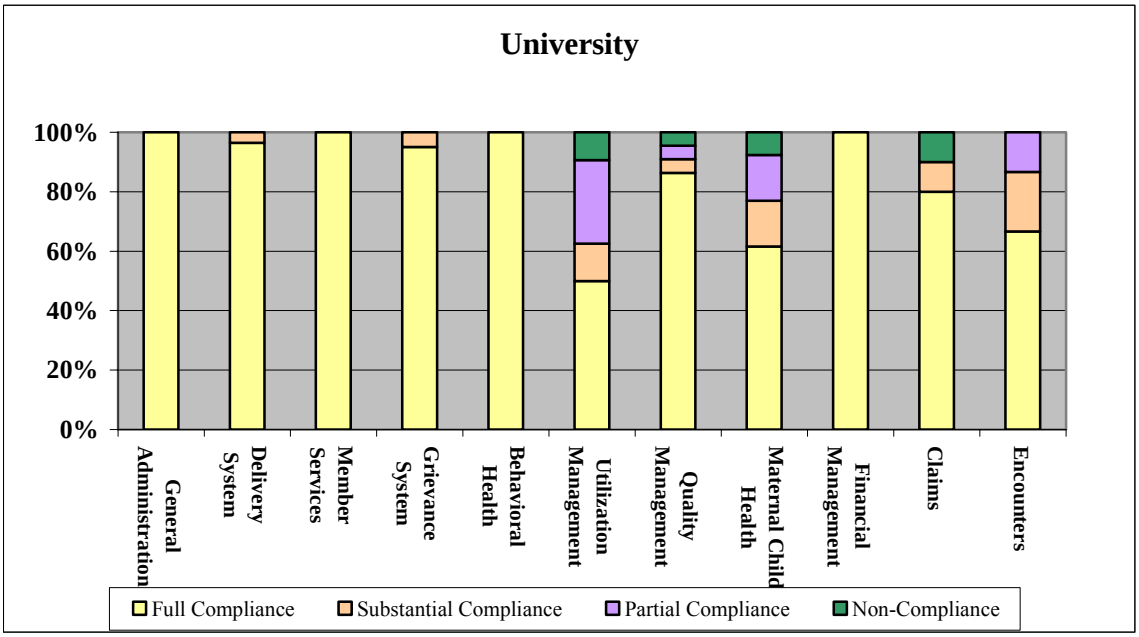


Figure 3-25 shows that all of the technical standards in general administration, member services, behavioral health, and financial management are in full compliance. Furthermore, under both the delivery system and grievance system, only one standard failed to be in full compliance although it was in substantial compliance. In contrast, utilization management showed half of the standards at less than full compliance. In total, 189 standards were in full compliance, 13 were in substantial compliance, 14 were in partial compliance, and six were in non-compliance.

CAPs for Compliance with Standards

Table 3-18 presents each category of technical standards reviewed, the number of CAPs required, the percentage of all CAPs in each category, the number of technical standards in each category, and the percentage of technical standards for each category with a CAP.

The table shows that, proportional to the number of CAPs, utilization management represents the greatest opportunity for improvement, receiving 44 percent of all CAPs. In addition, as a percentage of all the standards, maternal child health, claims, and encounters also present opportunities for improvement during the current review cycle.

Conversely, University did not receive any CAPs for general administration, member services, behavioral health, or financial management, making those categories recognized strengths. Additionally, delivery system only received one CAP. Overall, 14 percent of the technical standards required a CAP.

Table 3-18—CAP Overview *for* University				
Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
General Administration	0	0%	37	0%
Delivery System	1	3%	28	4%
Member Services	0	0%	21	0%
Grievance System	2	6%	20	10%
Behavioral Health	0	0%	7	0%
Utilization Management	14	44%	32	44%
Quality Management	3	9%	22	14%
Maternal Child Health	5	16%	13	38%
Financial Management	0	0%	17	0%
Claims	2	6%	10	20%
Encounters	5	16%	15	33%
Total	**32**	**100%**	**222**	**14%**

Performance Measure Review

Table 3-19 shows the performance measures results for the most recent two time periods, along with the statistical significance level for each of the changes in rates over time. Additionally, the table presents the CY 2004 Minimum AHCCCS Performance Standard and whether a CAP was required.

The table shows that 16 of the 22 comparable measures increased between the two time periods. Child immunization—DTP, IPV, & MMR (4:3:1 series) —Medicaid increased the most, at 8 percentage points. Well-child visits—first 15 months—Medicaid decreased the most, at 12 percentage points. Importantly, child immunization—1 MMR—KidsCare was at 100 percent for both time periods.

Of the 16 improved rates, four showed statistically significant changes. This finding suggests that 12 of the rates could be showing improvement due to sampling error and may not be a "true" increase. For the five rates that declined, only one did so meeting statistical significance. This finding also suggests that four of the declining rates did so due to sampling error and may not have been a "true" decrease.

Overall, the average change in rates saw an increase of 1.8 percentage points across the 22 comparable measures. Together with earlier findings, these results suggest a pattern that is slightly better than flat for University's performance measure review. Nonetheless, the average of all 26 rates shows that University was almost 5 percentage points higher than the average of the CY 2004 minimum AHCCCS performance standards.

Table 3-19—Performance Measurement Programs *for* University					
Performance Measure	Previous Measurement Period**	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Significance Level***	CY 2004 Minimum AHCCCS Performance Standard	CAP Required
Children's Access to PCPs – Medicaid	80.7%	79.5%	p=.091	79%	No
Children's Access to PCPs – KidsCare	81.6%	82.8%	p=.552	79%	No
Adults' Preventive/Ambulatory Care	77.0%	79.2%	p=.029	80%	Yes
Well-Child Visits – First 15 Months – Medicaid*	76.7%	64.3%	p<.001	70%	Yes
Well-Child Visits – 3 to 6 Yrs – Medicaid	51.2%	55.4%	p=.034	55%	No
Well-Child Visits – 3 to 6 Yrs – KidsCare	59.2%	61.7%	p=.716	55%	No
Adolescent Well-Care Visits – Medicaid	35.7%	38.0%	p=.130	32%	No
Adolescent Well-Care Visits – KidsCare	43.3%	46.6%	p=.344	32%	No
Annual Dental Visits – Medicaid	45.4%	51.9%	p<.001	49%	No
Annual Dental Visits – KidsCare	52.7%	59.6%	p=.009	49%	No
Child Immunization – 4 DTP – Medicaid	72.4%	78.8%	p=.138	83%	Yes
Child Immunization – 4 DTP – KidsCare	86.5%	85.7%	p=1.00	83%	No
Child Immunization – 3 IPV – Medicaid	89.5%	90.5%	p=.732	89%	No
Child Immunization – 3 IPV – KidsCare	100.0%	90.5%	p=.127	89%	No
Child Immunization – 1 MMR – Medicaid	91.7%	95.0%	p=.191	90%	No
Child Immunization – 1 MMR – KidsCare	100.0%	100.0%	p=1.00	90%	No
Child Immunization – 3 HiB – Medicaid	N/A[1]	86.0%	N/A[1]	76%	No
Child Immunization – 3 HiB – KidsCare	N/A[1]	90.0%	N/A[1]	76%	No
Child Immunization – 3 HBV – Medicaid	85.1%	90.5%	p=.101	82%	No
Child Immunization – 3 HBV – KidsCare	94.6%	95.2%	p=1.00	82%	No
Child Immunization – 1 VZV – Medicaid	80.3%	86.6%	p=.091	77%	No
Child Immunization – 1 VZV – KidsCare	86.5%	90.5%	p=1.00	77%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – Medicaid	68.9%	77.1%	p=.065	80%	Yes
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KidsCare	86.5%	85.7%	p=1.00	80%	No
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – Medicaid	N/A[1]	69.8%	N/A[1]	70%	Yes
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – KidsCare	N/A[1]	71.4%	N/A[1]	70%	No

*There were not enough KidsCare members who met the enrollment criteria to measure a rate for this group.

[1] Current and previous rates are not comparable due to a change in methodology. In the previous measurement, rates for two doses of HiB were reported.

** Children's access to PCPs and adults' access to preventive/ambulatory care, and child immunizations are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

*** Significance levels ($p \leq .05$) noted in the table demonstrate the statistical significance between the performance for the previous measurement period and performance for the current measurement period.

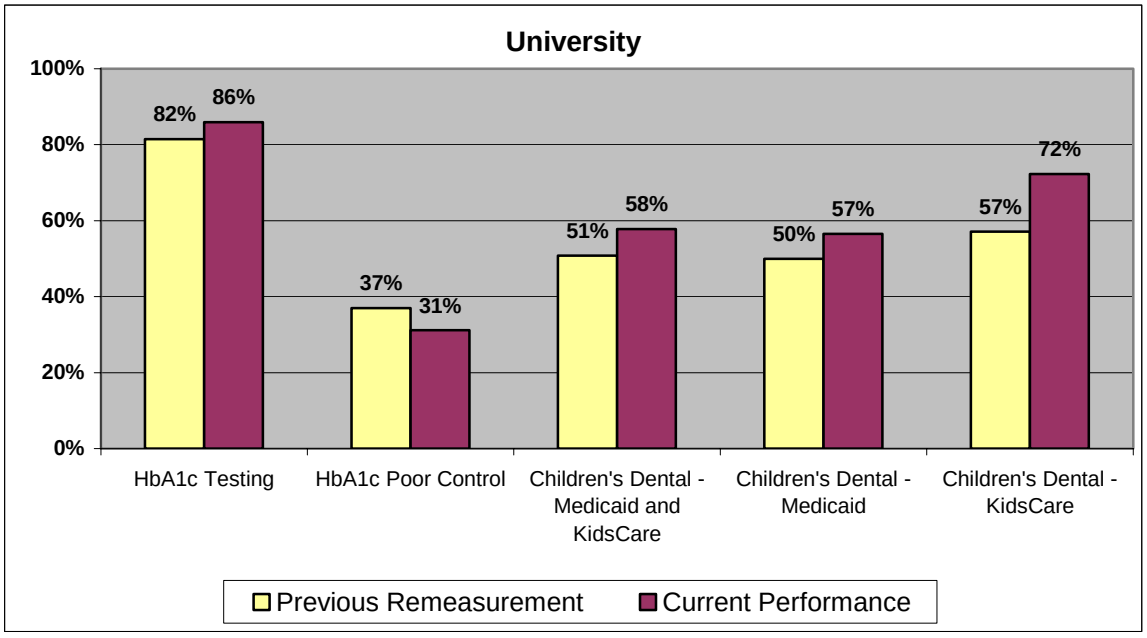
Performance Measures—CAPs

Five CAPs were required under University's performance measure results. Additionally, only one of the performance standards not currently requiring a CAP would have required one during the previous measurement cycle, using the same criteria used during the current measurement cycle. Of the five CAPs, three showed improvement between measurement cycles and one was not comparable due to a change in the measurement methodology between cycles.

Review of PIPs

Figure 3-26 shows that University made improvement in all measures associated with the PIPs, both for adult diabetes management and for children's oral health (the HbA1c poor control measure is a reverse measure for which lower values are better; therefore, the lower rate shown for the current measurement period represents improvement in the measure's rate). Some of these improvements were substantial. For example, the children's dental visits—KidsCare improved by a relative 26 percent. Furthermore, both measures of children's oral health met or exceeded the AHCCCS benchmark of 57 percent. Also, both closing adult diabetes management measures were near the top 10th percentile HEDIS® benchmarks.

Figure 3-26—PIP Review Results *for* University



Strengths, Opportunities for Improvement, and Recommendations for University

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

Figure 3-25 shows that general administration, member services, behavioral health, and financial management are in full compliance with all of their technical standards. Furthermore, delivery system and grievance system show that all of their technical standards are at least in substantial compliance. These categories of review, therefore, are relative strengths for University.

Opportunities for Improvement and Recommendations

Based primarily on Table 3-18 for the CAPs, but also shown in Figure 3-25, utilization management, maternal child health, claims, and encounters represent opportunities for improvement. Specifically, recommendations to improve performance by University can be summarized by the following:

- University policies, procedures, and processes need to be enhanced to include specific AHCCCS requirements related to:
  - Utilization management, prior authorization, and concurrent review.
  - Improving performance measure results.
  - Monitoring provider compliance with national practice guidelines.
- Specific areas of medical management that require improvement include:
  - Ensuring medically necessary supplemental nutrition is provided to eligible members of EPSDT age.
  - Monitoring member compliance with obtaining EPSDT services.
  - Monitoring member compliance with prenatal care within the prescribed time frames.
  - Monitoring health maintenance through disease management programs.
- Other areas of focus for University were concentrated in management of the plan. These focus areas include:
  - Ensuring written Notice of Intended Action forms are presented to members as required by AHCCCS.
  - Ensuring provisional credentialing meets AHCCCS-required timelines.
  - Ensuring that claims are processed and paid within AHCCCS time frames.
  - Ensuring that encounter ratios are within AHCCCS standards for performance.

Performance Measure Review

Strengths

University showed somewhat flat but relatively high performance for this review, with an increase of 1.8 percentage points across the 22 comparable measures. This relatively high performance (i.e. a strength) is evidenced by the 26 performance measures averaging almost 5 percentage points above the minimum AHCCCS performance standards.

Opportunities for Improvement and Recommendations

The relatively flat performance represents an opportunity for improvement. The recommendation is that University focus on methods to improve childhood immunization rates because three of the five CAPs involved immunizations.

Review of PIPs

Strengths

At this point, the adult diabetes management project is closed. All measures for both PIPs have improved. PIPs are, therefore, viewed as a strength moving forward. This finding is supported by the fact that both rates for children's oral health already meet or exceeded the AHCCCS benchmark. Both measures for adult diabetes management closed at approximately the top 10th percentile for the HEDIS® national benchmarks.

Opportunities for Improvement and Recommendations

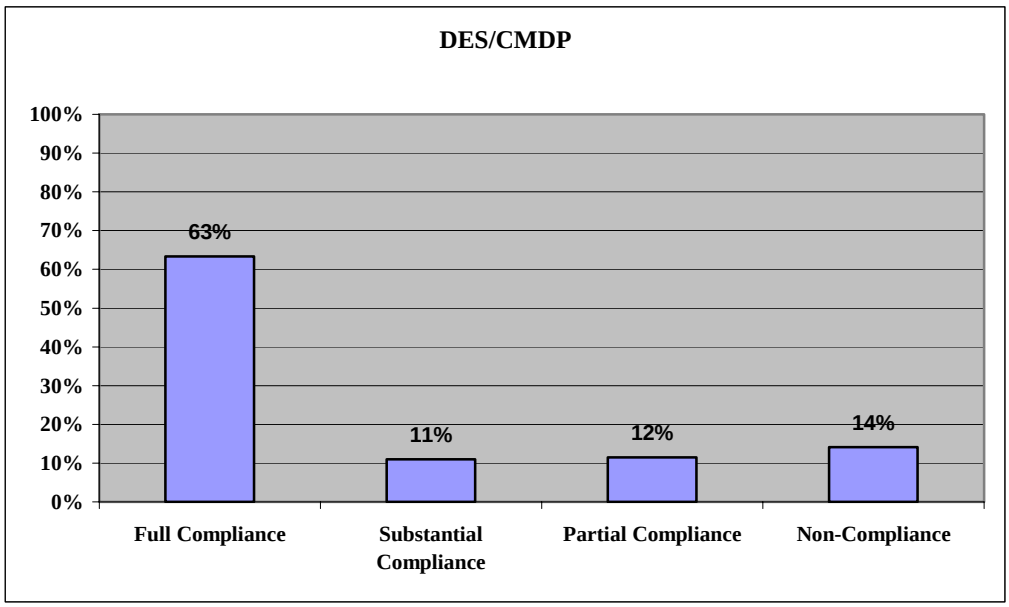
There are no recognized opportunities for improvement or recommendations at this time for University's PIPs. The adult diabetes management project was closed, and the children's dental health project appeared to be doing well.

Department of Economic Security Comprehensive Medical and Dental Program (DES/CMDP)

Compliance with Standards (Operational and Financial Review)

Figure 3-27 shows the DES/CMDP percentage of compliance with the technical standards selected for review in CY2004-2005. The percentages of the standards in full compliance, substantial compliance, partial compliance, and non-compliance are shown separately.

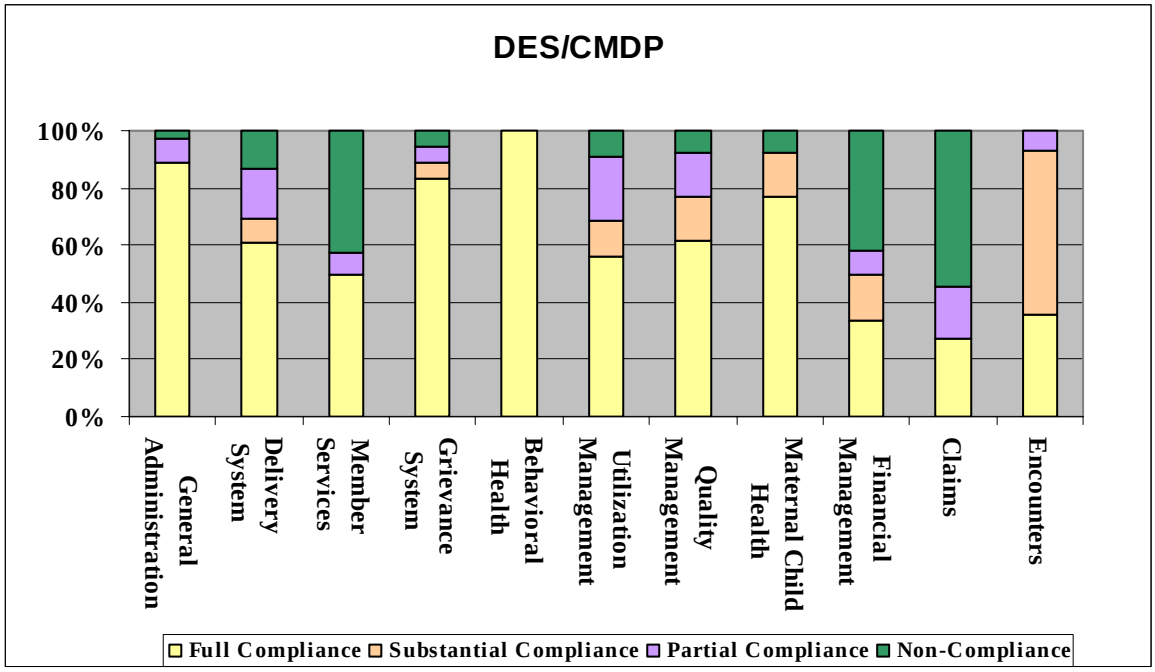
Figure 3-27—Compliance with Technical Standards *for* DES/CMDP



The difference between at least partial compliance (the sum of full, substantial, and partial compliance) and full compliance can be represented as 86 percent – 63 percent = 23 percent. This indicates a scenario in which the health plan seems to know the intent of the technical standards but is not achieving it fully. This scenario contrasts with the 14 percent in non-compliance, where the health plan might not understand the intent of the technical standards. In the first case (i.e. understanding but not fully achieving the technical standards), the health plan might make large strides in attaining full compliance with relatively little effort. Moving a technical standard from non-compliance to full compliance, however, might require additional educational and other activities.

Figure 3-28 shows the extent of compliance for each of the major areas within the technical standards. The figure highlights areas of strength and areas of opportunity for improvement. In each category, the figure shows the level of compliance with the technical standards based on full compliance, substantial compliance, partial compliance, and non-compliance. The figure also shows some large proportional compliance differences across the various categories.

Figure 3-28—Categorized Levels of Compliance with Technical Standards *for* DES/CMDP



The behavioral health category was in full compliance with all of the technical standards of the category. These results contrast with those found in the member services, financial management, and claims categories, where at least 40 percent of each category's technical standards were in non-compliance. In total, 121 standards were in full compliance, 21 were in substantial compliance, 22 were in partial compliance, and 27 were in non-compliance.

CAPs for Compliance with Standards

Table 3-20 shows each of the categories of technical standards reviewed, the number of CAPs required, the percentage of CAPs in each category, the number of technical standards in each category, and the percentage of technical standards for each category with a CAP.

The table shows that, proportional to the number of CAPs, utilization management represents the greatest opportunity for improvement, receiving 20 percent of the total number of CAPs. However, as a percentage of all standards, delivery systems, member services, utilization management, quality management, financial management, claims, and encounters also present opportunities for improvement during the current review cycle.

Conversely, DES/CMDP did not receive a single CAP for behavioral health, making that category a recognized strength. Overall, however, DES/CMDP received a CAP for 37 percent of all of the technical standards under review.

Table 3-20—CAP Overview *for* DES/CMDP				
Categories of Technical Standards	Number of CAPs	Percent of Total CAPs	Total Number of Standards	CAPs as a Percent of Standards
General Administration	5	7%	35	14%
Delivery System	9	13%	23	39%
Member Services	7	10%	14	50%
Grievance System	3	4%	18	17%
Behavioral Health	0	0%	6	0%
Utilization Management	14	20%	32	44%
Quality Management	5	7%	13	38%
Maternal Child Health	3	4%	13	23%
Financial Management	7	10%	12	58%
Claims	8	11%	11	73%
Encounters	9	13%	14	64%
Total	**70**	**100%**	**191**	**37%**

Performance Measure Review

Table 3-21 shows the performance measures for the most recent two time periods, along with the statistical significance level for each change in rates over time. Additionally, the table presents the CY 2004 minimum AHCCCS performance standards and whether a CAP was required.

Ten of the 11 measures that could be compared showed an increase in rates for DES/CMDP's performance measures for the two most recent measurement cycles. Of these, children's access to PCPs—Medicaid increased the most, at 9 percentage points. Well-child visits—first 15 months—Medicaid decreased the most at 8 percentage points, which was not statistically significant.

Only two of the 10 increases were large enough to reach statistical significance, suggesting that the rates for all other measures were statistically flat between the two measurement cycles. Nonetheless, the estimates for the rates showed an average increase of almost 4 percentage points and exceeded the Minimum AHCCCS Performance Standard average by almost 5 percentage points.

Assuming that the lack of statistical significance was due to relatively small sample sizes, the overall results suggest a small but noticeable degree of improvement in the performance measure rates between the two time periods under review for the comparable rates. This assumption is reasonable due to the moderate size of some of the increases in rates where statistical significance was not achieved.

Table 3-21—Performance Measurement Programs *for* DES/CMDP					
Performance Measure	Previous Measurement Period**	Actual Performance for Oct. 1, 2003, to Sept. 30, 2004	Significance Level***	CY 2004 Minimum AHCCCS Performance Standard	CAP Required
Children's Access to PCPs – Medicaid	79.1%	88.5%	p<.001	79%	No
Well-Child Visits – First 15 Months – Medicaid*	57.6%	50.0%	p=.469	70%	Yes
Well-Child Visits – 3 to 6 Yrs – Medicaid	61.4%	67.4%	p=.021	55%	No
Adolescent Well-Care Visits – Medicaid	59.8%	62.1%	p=.165	32%	No
Annual Dental Visits – Medicaid	68.9%	70.2%	p=.290	49%	No
Child Immunization – 4 DTP – Medicaid	74.1%	78.0%	p=.383	83%	Yes
Child Immunization – 3 IPV – Medicaid	87.3%	92.0%	p=.146	89%	No
Child Immunization – 1 MMR – Medicaid	93.7%	94.0%	p=.898	90%	No
Child Immunization – 3 HiB – Medicaid	N/A[1]	83.0%	N/A[1]	76%	No
Child Immunization – 3 HBV – Medicaid	75.3%	83.5%	p=.055	82%	No
Child Immunization – 1 VZV – Medicaid	77.2%	85.0%	p=.059	77%	No
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – Medicaid	67.7%	74.0%	p=.193	80%	Yes
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – Medicaid	N/A[1]	61.0%	N/A[1]	70%	Yes

*There were not enough KidsCare members who met the enrollment criteria to measure a rate for this group.

[1] Current and previous rates are not comparable due to a change in methodology. In the previous measurement, rates for two doses of HiB were reported.

** Children's access to PCPs and adults' access to preventive/ambulatory care, and child immunizations are measured and reported annually. All other performance measures are measured and reported on a rotating basis to allow health plans an intervention year between reporting periods.

*** Significance Levels ($p \leq .05$) noted in the table demonstrate the statistical significance between the performance for the previous measurement period and performance for the current measurement period.

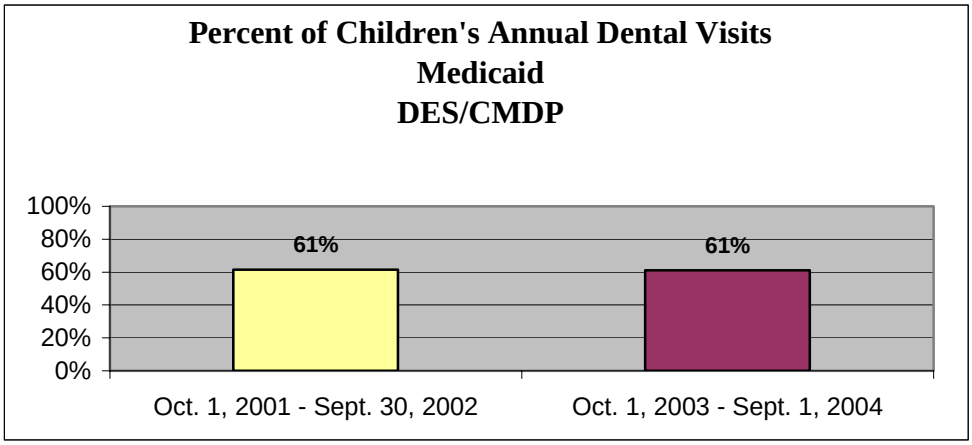
Performance Measures—CAPs

Four of the performance measures required a CAP this year. Of those not requiring a CAP, two would have required one during the previous measurement cycle using the same minimum standard. This finding supports improvement in DES/CMDP's performance measures between the measurement cycles reported here, as did the average increase in performance measure rates reported earlier.

Review of PIPs

DES/CMDP only participated in the annual dental visits—Medicaid measure for its PIP. Figure 3-29 shows the results for this project. The figure shows essentially flat performance between the two most recent measurement cycles, decreasing slightly from 61.4 percent to 61.0 percent. Nonetheless, the performance for both time periods shown in the graph exceeded the AHCCCS benchmark of 57 percent.

Figure 3-29—PIP Results *for* DES/CMDP



Strengths, Opportunities for Improvement, and Recommendations for DES/CMDP

The next three sections discuss: (1) compliance with standards, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

Compliance with Standards (Operational and Financial Review)

Strengths

Figure 3-28 shows that the behavioral health category was in full compliance with all of its technical standards and is a strength for compliance with standards.

Opportunities for Improvement and Recommendations

Based primarily on Table 3-20 for the CAPs, but also shown in Figure 3-28, delivery systems, member services, utilization management, quality management, financial management, claims, and encounters represent opportunities for improvement. Specifically, recommendations to improve performance by DES/CMDP can be summarized by the following:

- DES/CMDP policies and procedures need to be enhanced to include specific AHCCCS requirements related to:
  - Utilization management, prior authorization, and concurrent review.

- Performance improvement projects.
- Grievance and appeals monitoring.
- Cultural competency.

Additionally, the member information packet needs to contain the current member handbook and a comprehensive and current provider directory, and the provider manual needs to contain all required information.

- A number of training needs were identified, including:
  - Cultural competency for all staff.
  - Responding to member grievances.
- There were a number of standards related to provider network monitoring that were out of compliance. Specific areas requiring improvement include:
  - Monitoring and maintaining accountability for all functions that are delegated to other entities.
  - Verifying credentials of providers.
  - Monitoring provider compliance with national practice guidelines.
- Other areas of focus for DES/CMDP were concentrated in management of the plan. These focus areas include:
  - Ensuring Notice of Intended Action forms are presented to members in easily understandable formats.
  - Monitoring health maintenance through disease management programs.
  - Maintaining enough staff to monitor the provider network.
  - Utilizing grievance information to assess adequacy of provider network.
  - Providing written decision notice to providers about a claim dispute in specified time frames.
  - Maintaining accuracy and timeliness of financial reports.
  - Ensuring AHCCCS performance measures are used when reporting the performance of the health plan.
  - Ensuring proper notification is made for third party liability cases.
  - Ensuring that claims are processed and paid within AHCCCS time frames.

Performance Measure Review

Strengths

DES/CMDP showed moderate performance increases for this review, with an average increase of almost 4 percentage points across the 11 comparable measures. This increase is viewed as a relative strength for DES/CMDP.

Opportunities for Improvement and Recommendations

Well-child visits—first 15 months; child immunization—4 DTP; child immunization—DTP, IPV, & MMR (4:3:1 series); and child immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 series)

represent opportunities for improvement insofar as CAPs were required for these performance measures. The recommendation is that DES/CMDP focus on methods to improve comprehensive childhood immunization rates because three of the four CAPs involved immunizations.

Review of PIPs

Strengths

Performance that exceeded the AHCCCS benchmark suggests a relative strength for DES/CMDP's PIP.

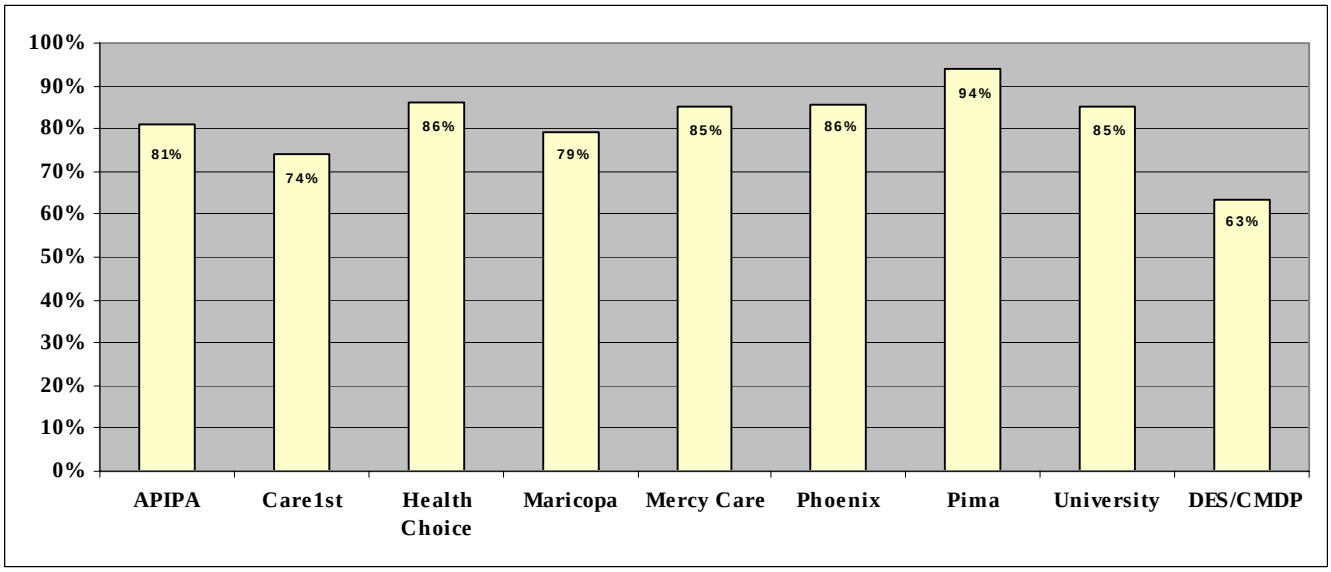
Opportunities for Improvement and Recommendations

The fact that performance was substantively flat suggests an opportunity for further improvement in DES/CMDP's PIP. The recommendation at this time for DES/CMDP's PIPs is to increase efforts to improve the children's dental visits rate, although the children's dental health project appeared to be doing well based on the current rate.

Compliance with Standards (Operational and Financial Review)

Figure 4-1 depicts the full compliance rates with the selected technical standards for all health plans. Two-thirds of the health plans were at least 80 percent in full compliance with the standards reviewed. Two health plans were below 75 percent of full compliance with these standards.

Figure 4-1—Full Compliance Comparison *for* All Health Plans



The performance of Pima is noteworthy from Figure 4-1. It shows that Pima was in full compliance with 94 percent of the reviewed technical standards. Pima's performance suggested that it was a best practice health plan for this area of review. Pima's operational methods could be emulated by other health plans to improve their performance on the technical standards. The figure also shows that DES/CMSP, at 63 percent of full compliance, had the greatest opportunity for improvement of its compliance with standards.

Figure 4-2 on the next page shows the extent to which each health plan was in full compliance, substantial compliance, partial compliance, and non-compliance for the technical standards reviewed.

Figure 4-2—Degree of Compliance Comparison *for* All Health Plans

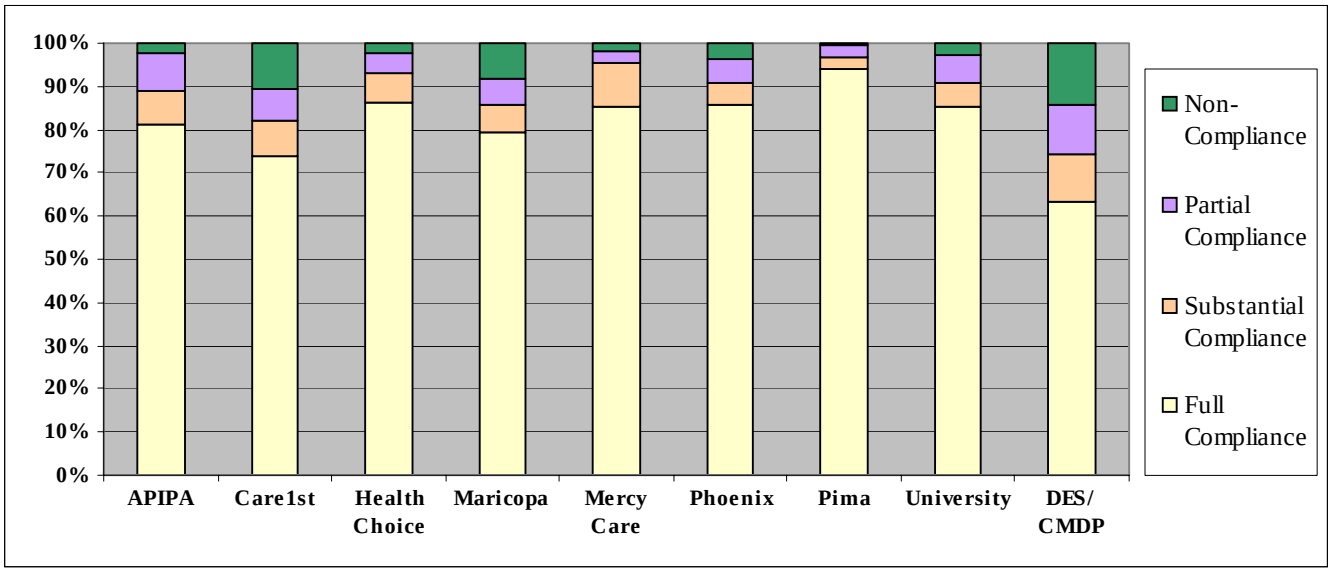


Figure 4-2 shows that five of the nine health plans (i.e., Health Choice, Mercy Care, Phoenix, Pima, and University) had more than 90 percent of the technical standards in full and/or substantial compliance. For these five plans, compliance with technical standards is a recognized strength in this technical report. APIPA showed that 89 percent of the technical standards were in at least substantial compliance, an achievement for which the health plan should be recognized. Only DES/CMDP fell below 75 percent for standards in at least substantial compliance.

For standards in non-compliance, Pima showed the lowest percentage at 0.5 percent, followed by Mercy Care at 1.7 percent. On the other end of the spectrum, DES/CMDP showed the highest percentage of standards in non-compliance at 14 percent, followed by Care1st at 11 percent. These standards in non-compliance represent compelling opportunities for improvement.

CAPs for Compliance with Standards

Table 4-1 presents the number of CAPs for each of the categories of technical standards and the total number of CAPs for each of the health plans. The table shows that with 12 CAPs, Pima clearly had fewer CAPs than any other plan. The plan with the next-closest total was University with 32 CAPs. Conversely, DES/CMDP showed the most CAPs with 70. The plan with the next-highest number of CAPs was Care1st with 55.

The table also shows the percentage of all CAPs and the expected percentage for each plan in the bottom two rows. The expected percentage reflects the number of applicable technical standards for each program contractor. The percentage of all CAPs shows the portion of all CAPs that each health plan had. Health plans with a percentage of all CAPs that was lower than the expected percentage did relatively well in the compliance with standards review. Where the percentage of all CAPs exceeded the expected percentage, the health plan had additional opportunities for improvement of its compliance with standards.

Table 4-1—CAP Overview *for* All Plans Individually									
Category	APIPA	Care1st	Health Choice	Maricopa	Mercy Care	Phoenix	Pima	University	DES/ CMDP
General Administration	4	3	1	0	1	2	2	0	5
Delivery System	6	11	7	6	10	0	0	1	9
Member Services	2	2	3	4	2	2	1	0	7
Grievance System	2	2	1	0	2	0	1	2	3
Behavioral Health	0	1	0	0	1	2	0	0	0
Utilization Management	9	5	7	6	2	11	2	14	14
Quality Management	12	15	4	4	8	3	2	3	5
Maternal Child Health	6	3	4	1	6	5	2	5	3
Financial Management	4	4	5	8	3	4	1	0	7
Claims	3	4	1	6	1	4	1	2	8
Encounters	1	5	4	7	3	2	0	5	9
Total	**49**	**55**	**37**	**42**	**39**	**35**	**12**	**32**	**70**
Percent of All CAPs	**13%**	**15%**	**10%**	**11%**	**11%**	**9%**	**3%**	**9%**	**19%**
Expected Percentage	**12%**	**11%**	**12%**	**11%**	**12%**	**11%**	**11%**	**11%**	**10%**

The results of the proportional analysis in Table 4-1 further reinforce earlier results. Pima received approximately one-quarter of the number of CAPs that would have been expected if all of the health plans had performed similarly on the review. Conversely, DES/CMDP received almost twice as many CAPs as a proportional distribution would predict.

Performance Measure Review

Table 4-2 presents the rates for all of the performance measures for the current review cycle along with the minimum AHCCCS performance standards. Where a cell lists N/A (not applicable), the health plan was not required to report the performance measure. The table also lists the average performance across all rates presented for each plan. Importantly, the rates must be interpreted with caution for plans where some of the rates are N/A. This issue is important because the distribution of minimum AHCCCS rates could favor or disfavor a plan with N/A-reported rates, depending on whether rates with relatively high or relatively low minimum AHCCCS performance standards are listed as N/A. As seen in the table, this issue only affects a comparison of average rates for Care1st and DES/CMDP.

Overall, Pima outperformed all the other health plans with a performance measure average of 81.7 percent. Health Choice shows the greatest opportunity for improvement in its performance measures by posting a lower average rate than any other fully comparable health plan's average rate (Care1st was excluded from this comparison due to the lack of fully comparable measures included in the averages). For only the fully comparable health plans, Health Choice was alone in not exceeding the minimum AHCCCS performance standard average rate.

Table 4-2—Most Recent Performance Measures *for* All Plans Individually

Category	APIPA	Care1st	Health Choice	Maricopa	Mercy Care	Phoenix	Pima	Univ	DES/ CMDP	Minimum AHCCCS Perfor-mance Standard
Children's Access to PCPs – MC	77.1%	69.7%	77.6%	66.5%	79.1%	77.1%	81.0%	79.5%	88.5%	79%
Children's Access to PCPs – KC	77.5%	71.6%	80.7%	68.8%	83.0%	78.7%	80.1%	82.8%	N/A	79%
Adults' Preventive/Ambulatory Care	77.8%	70.6%	76.7%	68.8%	79.8%	77.8%	78.1%	79.2%	N/A	80%
Well-Child Visits – 1st 15 Mon – MC	66.0%	N/A	70.8%	62.7%	69.6%	62.4%	72.5%	64.3%	50.0%	70%
Well-Child Visits – 3 to 6 Yrs – MC	56.6%	54.6%	58.2%	54.2%	56.7%	53.7%	55.5%	55.4%	67.4%	55%
Well-Child Visits – 3 to 6 Yrs – KC	57.1%	54.5%	68.0%	59.4%	62.5%	60.9%	62.9%	61.7%	N/A	55%
Adolescent Well-Care Visits – MC	32.9%	30.8%	32.6%	24.7%	32.5%	28.2%	34.8%	38.0%	62.1%	32%
Adolescent Well-Care Visits – KC	36.6%	34.4%	39.1%	27.4%	40.0%	32.4%	40.6%	46.6%	N/A	32%
Annual Dental Visits – MC	52.1%	50.5%	58.6%	37.9%	56.2%	56.3%	53.1%	51.9%	70.2%	49%
Annual Dental Visits – KC	58.7%	59.5%	69.1%	50.9%	68.2%	69.2%	60.1%	59.6%	N/A	49%
Child Immunization – 4 DTP – MC	80.7%	N/A	74.2%	90.1%	84.9%	86.6%	88.8%	78.8%	78.0%	83%
Child Immunization – 4 DTP – KC	87.4%	N/A	77.5%	93.1%	90.3%	93.5%	100.0%	85.7%	N/A	83%
Child Immunization – 3 IPV – MC	89.9%	N/A	85.5%	96.2%	92.0%	94.3%	92.8%	90.5%	92.0%	89%
Child Immunization – 3 IPV – KC	91.3%	N/A	88.8%	94.8%	94.9%	97.8%	100.0%	90.5%	N/A	89%
Child Immunization – 1 MMR – MC	90.7%	N/A	92.0%	96.2%	93.6%	94.3%	94.4%	95.0%	94.0%	90%
Child Immunization – 1 MMR – KC	95.3%	N/A	95.0%	93.1%	95.9%	97.8%	100.0%	100.0%	N/A	90%
Child Immunization – 3 HiB – MC	82.8%	N/A	82.2%	92.0%	87.5%	91.2%	92.8%	86.0%	83.0%	76%
Child Immunization – 3 HiB – KC	83.5%	N/A	83.8%	93.1%	90.8%	94.6%	100.0%	90.0%	N/A	76%
Child Immunization – 3 HBV – MC	87.8%	N/A	67.2%	90.9%	89.6%	92.0%	90.4%	90.5%	83.5%	82%
Child Immunization – 3 HBV – KC	89.8%	N/A	63.8%	89.7%	89.9%	95.7%	100.0%	95.2%	N/A	82%
Child Immunization – 1 VZV – MC	80.7%	N/A	84.6%	94.3%	83.2%	86.1%	91.2%	86.6%	85.0%	77%
Child Immunization – 1 VZV – KC	87.8%	N/A	91.3%	86.2%	89.4%	95.7%	93.3%	90.5%	N/A	77%
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – MC	77.5%	N/A	70.7%	88.2%	82.5%	85.8%	85.6%	77.1%	74.0%	80%
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KC	85.8%	N/A	73.8%	91.4%	85.7%	92.4%	100.0%	85.7%	N/A	80%
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – MC	69.3%	N/A	50.1%	77.6%	74.5%	80.9%	76.8%	69.8%	61.0%	70%
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – KC	76.0%	N/A	50.0%	84.5%	77.4%	88.0%	100.0%	71.4%	N/A	70%
Average of All Existing Measures	**75.0%**	**55.1%***	**71.6%**	**75.9%**	**78.1%**	**79.4%**	**81.7%**	**77.0%**	**76.1%***	**72.1%**

* Differences for these rates need to be interpreted with caution or, better, not at all due to the different mix of required measures for these health plans.

MC = Medicaid, KC = KidsCare

Performance Measures – CAP

Table 4-3 presents the CAPs for each performance measure for each health plan along with the total number of CAPs required. N/A signifies a performance measure that was not required to be reported by the health plan. This issue only impacts Care1st and DES/CMDP. All other health plans were required to report the full measure set. Nonetheless, the issue also impacts the interpretation of the relative totals for each of the individual performance measures. In most cases, only those measures that were required of all health plans should have their totals compared. An exception can be made when all of the measures required a CAP or when none of them did so.

For the eight health plans required to report their rates for adults preventive/ambulatory care, a CAP was required of each. This finding suggests an opportunity for improvement statewide for this performance measure. Conversely, no CAPs were required for any reporting health plans for annual dental visits – KidsCare, and for child immunization – 1 MMR, child immunization – 3 HiB, and child immunization – 1 VZV for both Medicare and KidsCare. These measures are recognized strengths across health plans for the performance measure review.

The table also shows that Pima only had one CAP required during the current measurement cycle. This finding contrasts with the 12 CAPs required of Health Choice. These findings are consistent with earlier findings from Table 4-2, where Pima showed strength on performance measure rates and Health Choice demonstrated opportunities for improvement for the same measures.

Table 4-3—CAPs for Performance Measures *for* All Plans Individually										
Category	APIPA	Care1st	Health Choice	Maricopa	Mercy Care	Phoenix	Pima	Univ	DES/ CMDP	Total CAPs*
Children's Access to PCPs – MC	Yes	Yes	Yes	Yes	No	Yes	No	No	No	5
Children's Access to PCPs – KC	Yes	Yes	No	Yes	No	Yes	No	No	N/A	4
Adults' Preventive/Ambulatory Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	8
Well-Child Visits–1st 15 Mon – MC	Yes	N/A	No	Yes	Yes	Yes	No	Yes	Yes	6
Well-Child Visits – 3 to 6 Yrs – MC	No	Yes	No	Yes	No	Yes	No	No	No	3
Well-Child Visits – 3 to 6 Yrs – KC	No	Yes	No	No	No	No	No	No	N/A	1
Adolescent Well-Care Visits – MC	No	Yes	No	Yes	No	Yes	No	No	No	3
Adolescent Well-Care Visits – KC	No	No	No	Yes	No	No	No	No	N/A	1
Annual Dental Visits – MC	No	No	No	Yes	No	No	No	No	No	1
Annual Dental Visits – KC	No	No	No	No	No	No	No	No	N/A	0
Child Immunization – 4 DTP – MC	Yes	N/A	Yes	No	No	No	No	Yes	Yes	4
Child Immunization – 4 DTP – KC	No	N/A	Yes	No	No	No	No	No	No	1
Child Immunization – 3 IPV – MC	No	N/A	Yes	No	No	No	No	No	No	1
Child Immunization – 3 IPV – KC	No	N/A	Yes	No	No	No	No	No	No	1
Child Immunization – 1 MMR – MC	No	N/A	No	No	No	No	No	No	No	0
Child Immunization – 1 MMR – KC	No	N/A	No	No	No	No	No	No	No	0
Child Immunization – 3 HiB – MC	No	N/A	No	No	No	No	No	No	No	0
Child Immunization – 3 HiB – KC	No	N/A	No	No	No	No	No	No	N/A	0
Child Immunization – 3 HBV – MC	No	N/A	Yes	No	No	No	No	No	No	1
Child Immunization – 3 HBV – KC	No	N/A	Yes	No	No	No	No	No	No	1
Child Immunization – 1 VZV – MC	No	N/A	No	No	No	No	No	No	No	0
Child Immunization – 1 VZV – KC	No	N/A	No	No	No	No	No	No	No	0
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – MC	Yes	N/A	Yes	No	No	No	No	Yes	Yes	4
Child Immunization – DTP, IPV, & MMR (4:3:1 Series) – KC	No	N/A	Yes	No	No	No	No	No	N/A	1
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – MC	Yes	N/A	Yes	No	No	No	No	Yes	Yes	4
Child Immunization – DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) – KC	No	N/A	Yes	No	No	No	No	No	N/A	1
Total Number of CAPs	**7**	**6***	**12**	**8**	**2**	**6**	**1**	**5**	**4***	**51**

* Differences for these totals need to be interpreted with caution due to the fewer number of required measures for these health plans.

MC = Medicaid, KC = KidsCare

Review of Performance Improvement Projects

Table 4-4 presents the adult diabetes management results for HbA1c testing for the two most recent measurement cycles. Although the table shows that not a single change in rates was significant, all of the health plans demonstrated improvement from the baseline to first remeasurement, and sustained that improved level of performance for the second remeasurement.

The table shows that five of the seven reporting plans had final rates of between approximately 80 to 85 percent. University achieved the highest final rate, at 85.9 percent, but was closely followed by Health Choice and APIPA. Phoenix had the lowest rate at 66.9 percent, followed by Pima at 77.0 percent.

The largest estimate for a positive relative change in rates between the two measurement cycles was for University at 5.4 percent, followed closely by Mercy Care at 5.3 percent. The largest estimate for a negative relative change in rates was for Pima at -4.2 percent followed by Maricopa at -2.9 percent.

Table 4-4—Performance Improvement Projects – HbA1c Testing *for* All Health Plans

Health Plan	Oct. 1, 2002, – Sept. 30, 2003	Oct. 1, 2003, – Sept. 30, 2004	Relative Change	Significance Level
APIPA	82.5%	85.2%	3.3%	p=.323
Care1st	N/A	N/A	N/A	N/A
Health Choice	83.2%	85.5%	2.8%	p=.436
Maricopa	83.6%	81.2%	-2.9%	p=.452
Mercy Care	78.8%	83.0%	5.3%	p=.154
Phoenix	65.4%	66.9%	2.3%	p=.693
Pima	80.3%	77.0%	-4.2%	p=.373
University	81.5%	85.9%	5.4%	p=.214
DES/CMDP	N/A	N/A	N/A	N/A
Total	**79.2%**	**80.7%**	**1.9**	**p=.220**

N/A = Not Applicable

Table 4-5 presents the adult diabetes management results for HbA1c poor control for the two most recent measurement cycles. For this measure, lower rates are better than higher rates. Only Health Choice's relative rate change of -24.9% reached statistical significance. Over all plans, though, the average relative change of 12.5 also reached statistical significance. Six of the 7 plans showed improved rates between the two measurement cycles.

The table shows that the final rates ranged from a low of 25.7 percent (i.e., the best rate change due to the measure being a 'reversed' indicator) for Health Choice to 46.5 percent (i.e., the largest opportunity for improvement) for Phoenix. The largest positive, relative gain (i.e., the largest decrease in rates) was seen for Health Choice at -24.9 percent. All of the health plans demonstrated improved performance from the baseline to the first remeasurement, and sustained that level of performance for the second remeasurement, which prompted AHCCCS to close the PIP.

Table 4-5—Performance Improvement Projects – HbA1c Poor Control *for* All Health Plans

Health Plan	Oct. 1, 2002, – Sept. 30, 2003	Oct. 1, 2003, – Sept. 30, 2004	Relative Change	Significance Level
APIPA	32.8%	27.3%	-16.8%	p=.109
Care1st	N/A	N/A	N/A	N/A
Health Choice	34.2%	25.7%	-24.9%	p=.022
Maricopa	38.3%	33.6%	-12.3%	p=.254
Mercy Care	32.6%	31.0%	-4.9%	p=.657
Phoenix	53.1%	46.5%	-12.4%	p=.104
Pima	37.2%	37.8%	1.6%	p=.886
University	37.0%	31.2%	-15.7%	p=.197
DES/CMDP	N/A	N/A	N/A	N/A
Total	**37.7%**	**33.0%**	**-12.5**	**p=.002**

N/A = Not applicable.

Table 4-6 presents the children's oral health results for children's annual dental visits, Medicaid. The table shows that only DES/CMDP did not achieve a statistically significant change in rates between the two most recent measurement cycles. Still, the statistically unchanged rate for DES/CMDP was higher than the AHCCCS benchmark rate. The significant change for Maricopa was a lower rate rather than a higher one. The rate for Maricopa was about 8 percent lower than the AHCCCS benchmark before Maricopa's rate declined to 16 percent below the standard. Compared with the other reporting health plans, Maricopa appears to have considerably more opportunity for improvement with Medicaid members in the next phase of the PIP.

The highest rate for the most recent measurement cycle was 61.7 percent for Health Choice, followed closely by DES/CMDP's rate of 61.0 percent. In total, five of the eight reporting health plans exceeded the AHCCCS benchmark. University was within 0.5 percentage points of meeting the standard. The best example of improvement was made by Health Choice, with a relative gain of 23.9 percent. The average relative gain over all of the reporting health plans was 10.5 percent, which was statistically significant. Overall, the children's oral health PIP for Medicaid members seemed to be going well, as evidenced by the results in the table.

Table 4-6—Performance Improvement Projects – Children's Annual Dental Visits *for* All Health Plans, Medicaid

Health Plan	Oct. 1, 2001, – Sept. 30, 2002	Oct. 1, 2003, – Sept. 1, 2004	Relative Change	Significance Level	AHCCCS Benchmark
APIPA	49.6%	55.2%	11.3%	p<.001	57.0%
Care1st	N/A	N/A	N/A	N/A	
Health Choice	49.8%	61.7%	23.9%	p<.001	
Maricopa	48.9%	41.0%	-16.2%	p<.001	
Mercy Care	53.6%	58.7%	9.5%	p<.001	
Phoenix	54.0%	59.0%	9.4%	p<.001	
Pima	51.3%	59.2%	15.5%	p<.001	
University	50.0%	56.5%	12.9%	p<.001	
DES/CMDP	61.4%	61.0%	-0.5%	p=.887	
Total	**51.4%**	**56.7%**	**10.5%**	**p<.001**	

N/A = Not applicable.

Table 4-7 presents the results of the children's oral health PIP for children's annual dental visits, KidsCare. The table shows that only Pima did not achieve a statistically significant change in rates between the two most recent measurement cycles. Still, the statistically unchanged rate for Pima was higher than the AHCCCS benchmark. The significant change for Maricopa was in the direction of a lower rate rather than a higher one. The rate for Maricopa had been higher than the AHCCCS benchmark before declining by a relative 18.1 percent during the most current measurement cycle, putting the rate below the standard. Compared with the other reporting health plans, Maricopa appeared to have considerably more opportunity for improvement with KidsCare members in the next phase of the PIP.

The highest rate for the most recent measurement cycle was 72.4 percent for Health Choice, followed closely by University's rate of 72.3 percent. In total, six of seven reporting health plans exceeded the AHCCCS benchmark. The best example of improvement was made by University, with a relative gain of 26.7 percent, followed closely by Health Choice's relative gain of 24.8 percent. The average relative gain over all of the reporting health plans was 12.3 percent, which was statistically significant. Overall, the children's oral health PIP for KidsCare members seemed to be going well, as evidenced by the results in the table.

Table 4-7—Performance Improvement Projects – Children's Annual Dental Visits *for* All Health Plans, KidsCare

Health Plan	Oct. 1, 2001, – Sept. 30, 2002	Oct. 1, 2003, – Sept. 1, 2004	Relative Change	Significance Level	AHCCCS Benchmark
APIPA	54.0%	62.4%	15.6%	p<.001	57.0%
Care1st	N/A	N/A	N/A	N/A	
Health Choice	58.0%	72.4%	24.8%	p<.001	
Maricopa	63.3%	51.8%	-18.1%	p<.001	
Mercy Care	64.2%	70.3%	9.4%	p<.001	
Phoenix	63.8%	70.9%	11.2%	p<.001	
Pima	66.0%	66.9%	1.4%	p=.880	
University	57.1%	72.3%	26.7%	p=.002	
DES/CMDP	N/A	N/A	N/A	N/A	
Total	**59.5%**	**66.8%**	**12.3%**	**p<.001**	

N/A = Not applicable.

Overall Strengths and Opportunities for Improvement

For the compliance with standards review, behavioral health technical standards were a strength across health plans, with only four CAPs required. Utilization management and claims showed the most generalizable opportunities for improvement across health plans. Pima faired substantially better across all compliance with standards categories than any other health plan. On the other end of the spectrum, DES/CMDP showed much room for improvement. The total number of CAPs DES/CMDP required for this review substantially exceeded the number of CAPs required of other health plans.

For the performance measure review, annual dental visits – KidsCare, child immunization – 1 MMR, child immunization – 3 HiB, and child immunization – 1 VZV are recognized strengths in general for the health plans. Not a single CAP was required for any of the measures. Adults preventive/ambulatory care showed the greatest opportunity for improvement with every reporting plan required to implement a CAP for that measure. DES/CMDP was not required to report a rate for adults preventive/ambulatory care.

For the PIPs review, the adult diabetes management project was generally quite successful for the health plans. Final rates compared well with national benchmarks, and most health plans sustained

and increased their improvement. The children's oral health project was also proceeding well and, in general, appeared likely to become a very successful project. Overall, the PIPs were strengths for most health plans. Only Maricopa appeared to have a substantial opportunity for improvement for its children's oral health PIP, demonstrated by substantively large and statistically significant declines in both Medicaid and KidsCare rates between the two most recent reporting cycles.

Overall Recommendations

The overall recommendations are tied to the general strengths and opportunities for improvement because specific recommendations for each health plan were delineated in the previous chapter of this report. For compliance with standards, it is recommended that all health plans, with the possible exception of Pima, either formulate or reconstitute a quality improvement team that is tasked with clearing current CAPs and implementing the systems and documentation necessary to avoid future CAPs. Full compliance for every technical standard should be both the goal and the expectation because the technical standards are well-delineated by the State.

For performance measures, it is recommended that health plans improve access for all members and implement comprehensive immunizations systems for all children. Doing so would likely resolve most, if not all, of the current CAPs. Access is not an easy issue and changing practice patterns to implement comprehensive immunizations systems is not any easier. Nonetheless, health plans are charged with succeeding with these issues. Successful examples exist for every current performance measure except adults preventive/ambulatory care. Two health plans were less than 1 percentage point from being successful with that measure.

For PIPs, the first recommendation is for Maricopa to redouble its efforts toward improving rates in the children's oral health PIP. APIPA and University could also use more successful interventions with their Medicaid members and, thereby, improve their performance rates to at least meet the AHCCCS benchmark. Other health plans appeared to be doing quite well with the project.